Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 2011 6:55 PM Serio Joseph David May Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Essex 1304 East Riverside Avenue 8. Date of Birth (Month, Day, Year) Aug 15, 1 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Country) Maryland **Funeral** Days 1 🔀 M 2 🗆 F Months 1949 61 Director 218-52-3116 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo Essex Baltimore Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 21221 States United 1304 East Riverside Avenue 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 ☐ Married Yes 2 No 0 þ Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospitals Carrier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even Nancy L. Hill Carmelo G. Serio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1304 E. Riverside Ave., Essex, Maryland 21221 Bonita Serio / Step-Mother Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/06/11 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Diabetes Mellitus Type II Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Pregnant at time of death Yes 2 □ No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be c 2 No 3 Probably 4 Unknown Records. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 s death? 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes မ 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide n 24 hours after death
ne Funeral Director: A
pleted filled in by the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 06 11 MD0067697 Sunch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sanchez-Crespo, 404 Eastern Blvd., Essex, Maryland 21221

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? = State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 0 rank Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** center IMOY MOYE 100 M ea If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year)

May 31, 1930 Days 1 **X** M 2 □ F OHIO 213-24-7430 81 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral 21122 within 72 hours after death with 8 Sunset Circle Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry 12 years <u>Crane Operator</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Pauline Unknown Snyder Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1242 Swanhill Court, Curtis Bay Maryland 21226 Saundra Snyder- DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Baltimore Maryland 6-6-2011 4 Donation 5 Other (Specify) Metro Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland, 21. Signature of Ameral Service Licensee Patrik Fleming 299 Frederick Road, Baltimore MD 21228 INC or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Mouth disease or condition Medical Due to (or as a consequence of): resulting in death) Nonth **Examiner** memy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗐 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Npatient 2 ER/Outpatient 3 DOA မ 1 Yes 2 No 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suici**d**e 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed The basis of examination and the support of the support of the basis of examination and the support of the supp within 2 To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD. 'KOHIT NIAL 06.05.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimor M D - 2120 roeme NIGL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June D2011 STREETT 6:15A ANNA SOMMERMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Presbyterian Home of MD 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X X 215-12-0341 0972377920 Maryland 90 **Director** or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral |915 Rappaix Court 21286 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis George Sommerman Marie Margaret Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson Albert Streett Son 170 Stanmore Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Stablers Church Cem 06/08/2011 Parkton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funer Le Ace License 22. Name and Address of FaMivtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Moulto Medical Due to (or as a cons uence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Yea Yes 2 No ed by the a detached f 9 Unknown 9 Unknown cate has been signed it page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cancer 1 Yes 2 No 3 Probably 4 Onknown Colon 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy perform 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural Natural
Accident
Suici 5 Pending within 24 hours after death

To the Funeral Director; /
completed filled in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗁 🧲 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tit 29c. License numbe ျ 29d. Date signed (Month, Day, Year, 71046 10 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI KUHAR NORTH BALTIMORE 21205 DM 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** John E. Selvey 2011 in /Medical Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore, Baltimore, City City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/24/1915 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√ M 2□ F Days Hours 029-10-4814 96 Scotland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Event Net 1 in Item 1 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 21 No MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1252 Sulphur Spring Road 21227 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★TXes 2□No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ Specify:White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 2 Food Industry Restaurant Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Hamilton-Harrison ပ John Selvev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne C. Ford-Selvey (wife) 1252 Sulphur Spring Road Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory 06/05/2011 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Homes, Inc. 1328 Sulphur Spring Ru Lober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stare Eno obstructive disease or condition resulting in death) Chropic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any teach of the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Selvey John Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 □ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50293 June 3. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 chio. MANZCHUS (00 AGNES E1 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June <sup>Day</sup> 2011 Janice Morgan Saury 2 9:05 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9335 Frostown Road Middletown Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Ye Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗘 🗆 F Country) Virginia **Director** 578-05-3467 93 1918 18 Feb item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fixen 27 is marked other than "natural". or nextly or other trainments. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9335 Frostown Road 21769 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black White etc. 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 ☐ Divorced SpecifyWhite Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Cameron Morgan Sadie Dobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Cameron Welch/granddaughter 9335 Frostown Rd. Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 06/08/2011 Woodbine, MD Signature of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition a Chronic Renal Failure Medical resulting in death) Examiner Hypertension Sequentially list conditions, Examine if any tracing to immediat cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and I-tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 **X**No certificate has been signed by the rector, page 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 2 🗆 No 1 Tyes Yes 2X No Be 25. Was case referred to medical director 26. Place of Death (Check only one) 2X No Hospital Other: ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Hame 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident Investigation To the Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Gettifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) June 6, 2011

State Registrar

DHMH 17 Rev 7/2009

100 S. Center St. Thurmont, MD 21788

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William F. Harper, M.D.

31. Date filed (Month, Day, Year)

11-04111 Tammy Smith

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

ammy Smith	1- For State	State of Maryland	Department of He Certificate of De		ygierie Reg. 1	201	18006
Physician/	Registrar  1. Decedent's Name (First,		- 11		Date of Death     Month     Date		3. Time of Death
Medical Examine	· ·	Tammy SM	100	To an Location of Doot	June 1, 2011	4c. County of Deat	1525 hrs
	4a. Facility Name (if not ins Maryland General	titution, give street and number) Hospital		y, Town, or Location of Death Itimore		40. Godiny of Doug	NA
Funeral	5. Social Security Number		- ()	Under 1 Year If Under 24Hr		/M/DD/YYYY) 9. Bi	gn
Director	218-04-445	4 1 M 2 F	41 Yrs. M	onths Days Hours Mir	Jane 1º	1,1969 c	ountry) Mary land
À:	Usual Residence of Deceder 10a. State 10b. Co		10c. City, Town or Location				10d. Inside City Limits
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the Maryland  or 23s-f show tified at once		FII D		Zip Code	10g.	Citizen of What Cou	intry?
The state of the s		Ins Falls Par	Fuerin II S 13 Was Des	21217  edent of Hispanic Origin? (S	necify Yes or No-	14. Race - Ame	rican Indian, Black,
r death with or items 23 must be no	11. Marital Status  1 Never Married 2	Married Armed Forces?		pecify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	acK
s after de rail", or niner mu	3 Widowed 4	Divorced If Yes, Give Year or Dates:	1 Yes	2 No specify:	1.	Specify:	
hours hatur Exami		(Specify only highest grade cor 0-12) College (1-4 or	5+) during most of	ual Occupation (Give kind of working life. DO NOT use re	tired)	b. Kind of Business	rinausti y
5-0036 cd within 72 hour lygiene. other than "natu the Medical Exar Completed	Elementary/secondary (	0-12) Gollege (1-4 01		Disabled		NA	
215-0036 so filed within 72 hours an total Hygiene, shed other than "natural ent, the Medical Examine Be Completed by	17. Father's Name (First, M	liddle, Last)		18.Mother's Nam	e (First, Middle, Mai	den Surname)	
21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		ationship (Type, Print )	19b. Mailing Add	ress (Street and Number or		r, City or Town, Stat	e, Zip Code) 21216
MD 21 d 2 should th and Me n 27 is ma numatic ev	Ebony Wit	y-daughter	4516	Bonner Rd.	Apt. C	Baltimo	re Maryland
re, M 1 and 2 f Health ff item 2 cr traun	20a. Method of Disposition  1 Burial 2 Cree	mation 3 Removal from St	ate 20b. Place of Disposition crematory or other pl	ace)	Date 2	Oc. Location - City o	r Town, State
Baltimore, oermit. Pages I an Department of He important: If ite injury or other tr	4 Donation 5 Ott	ner Specify:	Mt. LION	and Address of Pacility Pa	1 11	Landsdo	une marylara
Baltimorr permit. Pages 1 Department of 8 Important: If	21. Signature of Funeral &	ervice Licensee	/ 13C/2	Frederick /	TO DUTCH	imore, M	arriand
Physician	23a. Part I. Enter the day	e, or complications that caused	the death. Do not enter the mo	ode of dying, such as cardiac			A proximate Interval Between Onset and
/Medical	Immediate Cause (Final di	sease a. Hyperten	sive Cardiovas	cular Disease			Death
,=1	or condition resulting in de	h	equence of):				
190	Sequentially list conditions if any, leading to immediat cause. Enter Underlying (	e Due to (or as a cons	equence of):				
	(Disease or injury that initi events resulting in death)	ated C	sequence of):				
0), e be executed ysician and burial - transit		d	2701	( ( 20 11			
= 0 >-1 -	E LIC CENANI E.	23c. If yes, outco	,27, per me,g91	6 6-30-11 Sm		23d. Date of delive	ry
3876 rtificat ling ph	IF FEMALE: 23b. Was decedent pregna past 12 months?	nt in the 1 Live birth	2 Fetal de		nancy	Month	Day Year
eath eath for a	1 Yes 2 No 9		t time of death 5 Other	(Specify)			
Vital Records, P.O. Box registers. The law requires that the death his certificate has been signed by the atte director, page 2 should be detached for up and other for the property of the pr		conditions contributing to dea	th but not resulting in the under	lying cause given in Part I.			o the cause of death?
s, P.C					1 Yes - 24a. Was an		obably 4 Unknown
Records, The law requires ficate has been signage 2 should be					autopsy perform	prior to ed? death?	completion of cause of
Rec The la	5			26.Place of Death (Chec	1 Yes 2	No 1 🗸	Yes 2 No
Vital sician: is certi lirector		Hospital:	ient 2 🗹 ER/Outpatient 3	IOther .		esidence 6 Oth	er:
of Ving Physical After this Tool	27 Manner of Death	28a. Date of In (Month, Day,	jury Year) 28b. Time of Injury		28d. Describe ho	w injury occurred	
ttendin death.	1 X Natural 5 2 Accident	Pending		1 Yes 2 No	29f Location (Str	eet and Number or	Rural Route Number, City
Division of Vital Records, P.O. Appital or Attending Physician: The law requires that the next after death.  In a Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact	3 Suicide 6	Could not be determined (Specify)	njury - At home, farm, street, fa	ctory, office building, etc.	or Town, Sta		,
Fig to be		wine Physicians To the best of a	ny knowledge, death occurred	at the time, date and place, a	nd due to the cause(	s) and manner as st	ated.
Fo the vithin Somples	one) 2 Medic	al Examiner: On the basis of ex and manner stated	amination and/or investigation, I.			id place, and due to  29d. Date signed (A	
	29b. Signature and title of	certifier	D	29c. License number O.C.M.E.		June 2, 2011	лонин, Бау, геагу
x of d	30 Name and address of	person who completed cause of	death (Item 23a)				
) (	Ling Li, MD As	ssistant Medical Examin	er 900 W. Baltimore S	Street, Baltimore, MD	21223		
Sta		(,Year) 32 Registr	rar's Signature	1			
Registra	31 <b>2</b>	U I GULL CAN	- 1- 17				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 200 Robert Donald Seibert June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner BATTIMOTE WASHINGTON MESSEL CEN GLEN BURNIE ANNE Social Security Number 8. Date of Birth If Under 1 Year 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 1**X**XM 2 □ F Months Days 1 1 1 9 2 2 9 3 2 215 30 3127 78 MarwTand Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7129 Forest Ave. United States 21076 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Important: If item 27 Is marked other than "natural", or itei any injury or other traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 152-156 1 ☐ Yes 2 No Specify and Mental Hygiene.
Is marked other than "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Human Resources 12 Personal Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Edna Rachel Hamilton Walter George Seibert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Judith Seibert/Wife 7129 Forest Drive,Hanover,Maryland, 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 6/6/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, 7250 Washington Blvd., Elkridge, Maryland, 20175 of Funeral Service Licenses Kaufman Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sician/ SCHE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine thany leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year 4 ☐ Pregnant : 9 ☐ Unknown signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Diroctor, After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law autopsy performed Yes 2 1 Yes 2 • No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sigr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Certificate of Death Rea. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June Physician/ Super 2011 7:45 A M Steven Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore Co. Dunda1k 7445 Durwood Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) **Funeral** (Month, Day Year) Sept. 26, 1952 Months New Jersey Days 1 🔀 M 2 🗌 166-46-0952 Director 58 Usual Residence of Decedent 10d. Inside City Limits show 10a State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Dunda1k 1 Yes 2 No Baltimore 28a-f MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 Funeral 23a 7445 Durwood Road United States 21222 ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo If Yes, Give Year or Dates White "natural". 3 Divorced Completed item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Property Maintenance Maintenance Supervisor 10 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doris Henderson မ John Super 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 should Department of Health and M. Mportant: If Item 27 is mar any injury or other traumationce. 19a. Informant's Name/Relationship (Type, Print) Dundalk, Maryland 7445 Durwood Road Mrs. Erenda Super (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial XX Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp, 6/7/2011 ☐ Donation 5 ☐ Other (Specify) Duda-Ruck Funeral Home of Dundalk, Inc. 21. Sia Jure of Funeral Service icensee 7922 Wise Ave. Dundalk, Maryland 21222 ed the death. Do not enter the mode of dying, such as cardiac or rest iratory arrest Part 1. Enter the disease, or complications that cushock, or heart failure. List only one caus, on each Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to (or as a consequence or) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? Other (specify) 2 No the 9 Unknown t signed by the 23e. Did tobacco use contribute to the cause of death? conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other-significent Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performe 2 🗌 No 1 Tyes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: aP No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 욘 28b. Time of 28c. Injury at w<u>ork</u>? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury Certificate: (Month, Day, Year) 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No М To the Hospital or Attendir within 24 hours after death. To the Funeral Director. Ai Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 8 of death (Item 23a) (Type, Print) Name and address of person

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep  Registrar  Ce	artment of Health and Mental H	ygiene 2011 18009 Reg. No.
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	Day Voor
, 444	Medic	al	Britie C. Stiney	May	31 2011 7:10 PM
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Europal		Prince George Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)	CHEVERLY  If Under 1 Year I If Under 24 Hrs. 8, Date of B	PRINCE GEORGE'S  iirth 9. Birthplace (State or Foreign
	Funeral Director		227-46-3741 1□M2KJF 74 Yrs.	Months Days Hours Min. (Month, D. JULY	20 1936 Country) VA
	T OM		Usual Residence of Decedent		
	ırylanı a-f sh ied a	Director	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits 1 X Yes 2 □ No
	or 28g	声	10e. Street and Number	UPPER MARLBORO  10f. Zip Code	10g. Citizen of What Country?
	23a st be	Funeral	722 COFFREN PLACE	20774	USA
	tems er mu	표		Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	D- 14. Race - American Indian,
36	after c	þ	1 Never Married 2 A Married 1 Yes 2 X No	1 ☐ Yes 2 X No Specify:	Black, White, Clar
Ö	ours a	etec	3 U Widowed 4 U Divorced Year or Dates.		Specify: BLACK
15	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working OO NOT use retired)	16b. Kind of Business Industry
21215-0036	within giene. ner thai t, the N		Elementary/Seconday (0-12) College (1-4 or 5+) SCI	HOOL BUS AIDE	GOVERNMENT
pu	B £ 5 5	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
Sa	should be file h and Mental I 7 is marked o rraumatic eve	-	ROBERT L. TOLER	GOLBIE NICHO	
Maryland				ng Address (Street and Number or Rural Route Numl COFFREN PLACE, UPPER MA	
ā,	f Heal		20a. Method of Disposition 20b. Place of Dispo	osition (Name of Date	20c. Location - City or Town, State
E	Page 1 int: If ii ry or c		1 21 Danial 2 - Oremation 3 - Nemoval normatate	TION CEME. 6/7/2011	CLINTON, MARYLAND
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other				NKINS FUNERAL HOME
_	90 E # 9			474 LANDOVER ROAD, LANDO	VER, MARYLAND 20785
			23a. Part 1 Enter the disease, or complications that caused the death. Do not ent shock or hear to liure. List only one caus, on each line.	er the mode of dying, such as cardiac or respiratory	
-	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	5 earna	Onset and Death
نب	Examiner		Due to (or as a confedence of):	ten disease	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):		
	outed nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or linjury that initiated events  c.	e Cardiovacular disea	are
	e be executed ysician and e burial-transit	ical E	resulting in death) Last Due to (or as a consequence of):		
	ate by physic the b	adic	d		
Box 6876	eath certificate b attending physi I for use as the b	ľV.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
30X	eath o	icia	in the past 12 months?  1 Use Birth 2 Fetal death 3 I Pregnant at time of death 5 I	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
O.E	the d by the tacher	Physician/Med	g Unknown		
, P.O.	r requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the MASS (VC ASPINATION PARAMONIA	bilateralla	tobacco use contribute to the cause of death?
rds	equire	Completed by	Massive aspiration preumonia Diubetes mellitus		Yes 2 No 3 Probably 4 Unknown
900	has the	ldm		24a. Wa	s an 24b. Were autopsy findings available prior to completion of cause of death?
Œ E	sician: The law certificate has rector, page 2.		St MS is	1  \( \sum \) Yes  26. Place of Death (Check only one)	s 2 4 No 1 Yes 2 No
Vita	ysicia s cert direct	To Be	examiner?  1  Yes 2  No  Hospital: Inpatient 2  ER/Outpatie	_ Tother:	sidence 6 Cther (Specify)
of	ng Ph ter thi		27. Manner of Death 28a. Date of injury 28b. Time of injury 1 Natural 5 Pending (Month, Day, Year) injury	, T	e how injury occurred
ion	tendii Jeath. Ior: Ai the fu	ifica	2 Accident Investigation	M 1 🗆 Yes 2 🗆 No	
Division of Vital Records,	Hospital or Attending Physician: The law requires that the death certificate 44 hours after death.  Funeral Director: After this certificate has been signed by the attending phy therefure the funeral director, page 2 should be detached for use as the	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)		(Street and Number or Rural Route Number, own, State)
Ω	spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, and due to the	cause(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examiner: On the basis of examination and/or invest only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at the time, date	e and place, and due to the cause(s) and manner stated.
_	Vith Coat		29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1mp		10/0	DO043662	June 1,2011
_	08		30. Name and address of person who completed cause of death (Item 23a) (Type, William BOY(e PG Ho(hrta).	<sup>Print)</sup> 3001 Hospital D <b>rive,</b> Hya	ttsville, MD 20785
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Registra	ar	JUN 0 7 2011 Person A. Sale	<b>9</b>	

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 30<sup>ay</sup> Cleveland 2011 Crawford Segers Sr. 12:45 A<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Y Sept 16 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 245-26-4105 84 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Hyattsville X Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 819 Thurman Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 2 should be filed within 72 hours after dear lith and Mental Hygiene.
27 is marked other than "natural", or iter traumatic event, the Medical Examiner reaumatic event, the Medical Examiner. Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government Postal Manager 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Baker Page 1 and 2 should be 1 ment of Health and Menta Etta Howze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Thurman Avenue, Hyattsville, MD 20783 27 Enda M. Segers/ Wife item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 06/09/2011 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) Veteran Cemetery 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Prier the disease, or complications that caused to shock or heartifadure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 7474 Landover Road, Landover, MD 207<u>85</u> sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Toscleron Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ₽ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse B actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 7/2009

Washington

32. Registrar Signatur

Adventist Hospital,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) June 2011 12:30 AM Physician/ Silate Μ. Susan Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel 1028 Cayer Drive Apt 601 Glen Burnie 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under Year If Under 24 **Funeral** (Month, Day, Year) 1 🗆 M 2 🗷 F Days Hours Min Country) Sent .1954 Maryland Director 215-64-4920 56 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral IL.S 1028 Cayer Drive 601 21061 Apt. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces' 1 ☐ Yes 2 🗷 No If Yes, Give 1 Never Married 2 Married ò Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) within 7 Elementary/Seconday (0-12) Dependent Dependent 12 N/A other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other them. 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) P Anna Brandt Wilbur Granger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cynthia A. Silate (Daughter) 12 Birsay Court Nottingham, Maryland 21236 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Cremation 06/06/2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5 en Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Re **Examiner** Sequentially list conditions a consequence of Examine cause. Enter Underlying 2 burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician s the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No ate has been signed by the atte-page 2 should be detached for Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) funeral director, 25. Was case referred to medica To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 X No this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: After t 5 Pending 1 Natural s after death. 1 Yes 2 No Accident Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

(+ARVIT 5, BA5A5, 3455, WILKEN AVE 13aCt www. Day, Year) 31. Date filed (Month, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 3, Physician/ 2:02 PM 2011 William Henry Sachse Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Harford Bel Air Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 1f Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jun 30, Months Davs Hours 69 Maryland Director 214-40-9956 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔨 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 United States 2410 Eagle View Dr. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

Yes 2 \( \square\$ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sun Paper Printer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Henry Greenwood Sachse Lorrine Lovell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 19a. Informant's Name/Relationship (Type, Print) Jennifer Hatfield /Daughter 226 S. Washington St. Main Havre De Grace, Health tem 27 i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl Jun 06 cemetery, crematory or other place) 1 Burial 2 Scremation 3 Removal from State Beltsville, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Signature of Funeral Service Linewsee Name and Address of Facility
Cremation and Funeral Alternatives 16 Decc 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Tesente Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ile colitis 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hepato cellular carcinoma autopsy Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 2 No ျ 1 Apatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Division of 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 Atural  $5 \square$  Pending Accident Investigation 24 hours after deatl 3 \subseteq Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29c. License number DO053568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pson th, Day, Year) 2. Registrar's Signature iled (Ma State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MILDRED SHEPPARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3556 Blue Ball Rd. Cecil Elkton Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Aug 29 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Hours Months 94 Maryland Director 1916 216-09-1798 Usual Residence of Decedent or 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21921 United States 3556 Blue Ball Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner n 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify: Specify: 3 Nidowed 4 □ Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 it of Health and Mental Hygiene. If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Jacob Noz Fannie Stoewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fay Mathis /Daughter 3556 Blue Ball Road Elkton, MD 21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jun 0 Beltsville, Maryland 2011 Chesapeake Crematory Signature of Funeral Service Licenser 22. Narce and Address of Facility Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of and burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown jo Day Month Year 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Hospital or Attending Physician; The law requires 2 No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and certi MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT WOLF, MD 23 E. MAIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other				ke Crem		_i			sville	, MD	
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χ	th ce ttend or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Feta	l death 3	Ectopic preg	ınancy			230	d. Date of delive	·	
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21	/		30. Name and address of person LORETO S. ALBI					7E. #2	.05 RF	THESDA	MD	20814		
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DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Keven Seal	1.	For State	ate of N	/laryland	-	artment o rtificate o	f Health an f Death	d Menta	Нуд		eg. No.	20	Bases of	18015
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10re, MD 21215-0036 spes I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  It If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic evect, the Medical Examiner must be optified at loose.  To Be Completed by Funeral Director	١L		arried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Give Year	? (X) No		as Decedent of Hi res, specify Cuba Yes 2 X No	n, Mexican, Pu				4. Race - 7 White, e	etc.	n Indian, Black,
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Baltimore, MD 21215-C permit. Pages I and 2 should be filed v Department of Health and Mental Hygi Important: If item 27 is marked otha injury or other traumarite evect, the injury or other traumarite.		0a. Method of Disposition  Burial 2 X Cremation  Donation 5 Other S	pecify:		rate Fi	crematory or ot inal Jou	ırney Cr	em. 6/		<sup>ate</sup> 2011		dbine		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicino: The law requires that the death certificate be within 24 hours after death.  To the Fuoeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buildedical Certification: To Be Completed by Physician/Med	IF 23	FEMALE:  b. Was decedent pregnant in the past 12 months?  Yes 2 No 9 Uni	1 _ 1 _ 4 _	. If yes, outco Live birth Pregnant at		2 Fe	tal death 3 her (Specify)	Ectopic pro	egnancy			Date of de nonth	livery Day	y Year
P.O. By that the degree by the electroched for by the by the by the by the by the by Phy		art II. Other significant condit			h but not r	esulting in the t	underlying cause	given in Part I.						e cause of death?
Division of Vital Records, P.O. tal or Atteodiog Physiciae: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach serification: To Be Completed by P									_	24a. Was autop	an osy rmed?	24b. We prio dea	re autop r to con th?	osy findings available inpletion of cause of
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Division o spital or Atteodiog nours after death. oeral Director: After filled in by the func Gertification:	3	Suicide 6 🗶 Coul	stigation 28		njury - At h		0 pm 1 det, factory, office to	Yes 2 x No		nknowi Location (S or Town, S	Street and	d Number o	or Rural	Route Number, City
Divis  C. Hospital or A  1.24 hours after  F. Woeral Dire  letely filled in b		Pa. Certifier 1 Certifying P	nysician: To	the best of m		ge, death occur	red at the time, d		and due	to the caus	re,M se(s) and	d. manner as	stated.	
To the Ho within 24 h To the Fuc completely	25	9b. Signature and title of certifie	and m	e basis of exa nanner stated.	mination a	and/or investiga	29c. Licens		ed at the	e time, date				n, Day, Year)
	3/	D. Name and address of person	who comple	> ted cause of :	leath (lion	23a)	O.C.	M.E.			June	6, 2011	201710	
S y	1	Ling Li, MD Assista		l Examine	г 900	W. Baltimo	e Street, Bal	timore, MD	2122	3				
State Registra		1. Date Moath, Day Year)	Den	32. Registra		barket.				_				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First\_Middle\_Last) 2. Date of Death Physician/ Thelma Iolia Trageser June 2011 3 9:06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good Samaritan Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year)
1ay 25,1923 Baltimore, 1 □ M 2X F Months Hours 215-12-8477 88 Director Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location at 10d. Inside City Limits Director Examiner must be notified MD Baltimore Parkville 1 🗌 Yes 2 🗓 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 8800 Old Harford Road 21234 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Banking 10 Accountant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ John Smith be . Mary Katherine Monberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8733 Stockwell Road, Parkville, MD 21234 permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau Kay Barrett- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith Rosedale, Maryland 4 Donation 5 Other (Specify) Cemeterv Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility **Evans** Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 as. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death nock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Ph\_sician/ disease or condition resulting in death) Bleec Medical Due to or as a consequence of) **Examiner** per tension Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or a a consequence of) and I-transit Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 month 1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Dav detached the 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performe this certificate 2 🗌 No 1 Yes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes |은 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death e Hospital or Attending Pl n 24 hours after death, the Funeral Director: After the collected filled in by the funera Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled in 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie H0068996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Patricia 9

31. Date filed (Month, Day, Year)

ugene

5601

Loch Raven BIVG

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shelby J. Trent 4 Day 201 Year June 10:44am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Dec. 7, 1939 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2**X** □ F 227-46-8900 Country) Director 71 Yrs Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore White Marsh 1 Yes 2 XNo 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 11505 Jerome Avenue 21162 USA items ? 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 9 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed ed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12th is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Neal Ella Swain Important: If item 27 is marke any injury or other traumatic once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a 11505 Jerome Avenue White Marsh MD 211 Lewis R. Trent Jr./husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State Baltimore MD Holly Hill Cemetery 6/8/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave.
Connelly Funeral Home of of Funeral Service Licenses Balto. MD Essex 21221 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ e tallali disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Errier Universitying Cause (Disease or linjury Due to (or as a consequence of) that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Year Day 4 ☐ Pregnant 9 ☐ Unknown ed by the a 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed' Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🖵 🇲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certifier Signature and 29c. License number 29d. Date signed (Month, Day, Year) MD D71040 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHAR CHARLES SUTTE 4105 BALTIMORE MD State JUN 0

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. Pecedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 520A M trey 2011 lohn une /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 215-82-6603 42 Yrs 26, 1968 New Hampshire **Director** Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2300 Crest Road 21209 U.S.A. Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 Tes 22
If Yes, Give
Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Aquarium Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Director of Government Relations in Baltimore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental I marked Lucille Ann Masciulli Joseph John Topping ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 of Health Wengi Liu Topping (wife) 2300 Crest Road Baltimore, Maryland 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Church Cemetery 6-7-11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 2 Name and Address of Facility litchell-Wiedefeld Funeral Home, Inc 6500 York Road Baltimore, Maryland 23a. Part 1. Eviter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21212 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) sangrene /Medical Due to (or as a conseq or e of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) n signed by the att uld be detached fo 2 No Yes Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 🗌 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No 3 DOA 2 FB/Outpatient 5 Residence 6 Other (Specify) ၉ this completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours after death. Certification: 1 Natural (Month, Day Year) Injury Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 \( \text{Homicide} \) City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3,2011 CS -000

Registrar

DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

annia

inders

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 19:20 ERONICA JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) /- 30-1963 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 212-84-414 Days 19 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location items 23a or 28a-f show her must be notified at 1 Yes 2 □ No Director more 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21201 1102 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I 1 Never Married 2 Married 21215-0036 1 Yes 2 40 If Yes, Give / Year or Dates: Specify þ 3 Widowed 4 Divorced Blac Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) marager 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Maryland Be ဂ္ athaniel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2120 charlene Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 I I 4 Donation 5 Other (Specify) Dundalk 10,2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor ST w Ylie tuNeral Home Part / Enter the disease, or omplications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) )/Medical Due to (or as a consequence of): Examiner 6 MONTHS MYELOGENOUS LEUKEMIA Sequentially list conditions, if any, reading continuous cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and d for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Year detached for in the past 12 months? Month Day 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 27. Manner of Death Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Director: After (Month, Day Year) Injury or Attending 1 Natural 1 Yes 2 🗌 No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after Hospital 24 hours 29a. Certifier (check only 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated To the I within 2 29c. License number 29b. Signature and title of certifier

Registra

DHMH 17 Rev 1/200

State

30. Name and address of person w

31. Date filed (Month, Day, Year, JUN 0 7 2011

KHWAJA

completed cause of death (Item 23a) (Type, Print)

MD

Yousuf.

RESOOO

JUNE 3, 2011

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Relindis M. Tim 9827AM mar Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Doctors Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. . Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 XF (Month, Day, You Sept 17 **Director** Yrs 219-55-2278 32 1978 Cameroon Usual Residence of Deceden 10a. State the Maryland 10b. County 10c. City, Town or Location Director 10d Inside City Limits or 28a-f sl notified MD Prince George's New Carrollton 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code ıral", or items 23a or I Ex. miner must be 10g. Citizen of What Country? Funeral death with 20784 6805 Goodluck Road IISA 12. Was Decedent Ever in U.S. Armed Forcee? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. þ within 72 hours after 1 Ves 2 No Specify "natural" Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other thany injury or other traumatic event. \*\*\*\* 12th Nurses Aide Private Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည Emmanuel Tim Frida Onekon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcus Onekon 6805 Goodluck Road, New Carrollton, MD 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State NAT'L CEMETERY 06/11/2011 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MARYLAND . Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final

Metastatic Breast Cancer Onset and Death Physician/ Metastatic Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy
performed?

Yes 2X No the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h death? 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2X No Other: ဂ္ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation in 24 hour. the Funeral Directory and filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) cal 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 within 2 To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) D64268 05/25/2011

State Registrar Royce A. Burns, 8118 Goodluck Road, Lanham, Maryland 20706

32. Registrary Signat

address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certifi	nent of Health and Mental	Reg. N		10.41
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		Date of Death     Month Dar	v Year	Time of Death
Medical Examiner	Lillian Thieme  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dec	May 28, 2011	4c. County of Death	1457 hrs
	Baltimore Washington Medical Center	Glen Burnie		Anne Arundel	
Funeral Director	5. Social Security Number 218-80-8838 6. Sex 7. Age (In yrs. last b		Irs. 8. Date of Birth (M	M/DD/YYYY) 9. Birth Foreign Coun	olace (State or try) Md.
any		vn or Location		1	0d. Inside City Limits
<b>E</b>		Burnie			1 Yes 2 X No
eath with the Maryland riems 23s or 28s-f sho ust be notified at once. Inneral Director	10e. Street and Number 1000 7th Street	10f. Zip Code 21060		U.S.A.	
rer death with , or items 23 r must be no	11. Marital Status  1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Yeer	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		14. Race - America White, etc.	
ours aft	or Dates:	a. Decedent's Usual Occupation (Give kind o		b. Kind of Business/Inc	
5-0036 ed within 72 hour lygiene, other than "natu the Medical Exan Completed		during most of working life. DO NOT use n Homemaker		Own Home	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medical To Be Comple	17. Father's Name (First, Middle, Last)  James Franklin Broadwater		ne (First, Middle, Maid nn Staton	en Surname)	
MD 212 d 2 should be lith and Ment in 27 is mark	19a. Informant's Name/Relationship (Type, Print )	9b. Mailing Address (Street and Number of 819 Broadview Blvd.			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked offer than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 X Burial 2 Cremation 3 Removal from State crem	e of Disposition (Name of cemetery, atory or other place) r Hill Cemetery 6/		c. Location - City or To	own, State
Balti permit. Departn Importi injury o	21. Signature of Funeral Service Licenspe	22. Name and Address of Facility $G_{\rm C}$ 4001 Ritchie Hwy	Balto. Md	. 21225	
Physician /Medical	23a. Part I. Enter the disease, or complications that ca ded the death. Do failure. List only one cause on each line.		or respiratory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. UXYCOGONE and Et Due to (or as a consequence of):	chanol Intoxication			20001
19	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
ed nsit <b>Examiner</b>	Cilisease or injury that initiated events resulting in death) Last				
and transit	d	01/ ( 0	1 1		
60, ate be executed hysician and te burial - transit Medical Exi	IF FEMALE: 23c. If yes, outcome of pregnance	n-f,per me,g916 6-8-		23d. Date of delivery	
). Box 6876 the death certificate by the attending phy ched for use as the I Physician/M	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic prec		Month Da	y Year
Box te death the atte ted for u	1 Yes 2 No 9 Unknown				
ires that the signed by the detach	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.		co use contribute to th	
(ecords, The law requires are has been sig age 2 should be			24a. Was an autopsy		psy findings available mpletion of cause of
Recc The lay ficate ha			performed 1 ✓ Yes 2	l? death? No 1 ✔ Yes	2 No
Vital Recystrian: The his certificate director, page	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/	26.Place of Death (Checoupatient 3 DOA Outpatient 3 Nur	k only one)	idence 6 Other	
n of Vi ling Physi After this funeral dii	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	p. Time of Injury 28c. Injury at Work?	28d. Describe how i		
Sion Attendi death. ector: by the fi	Z Accident investigation	2:00 pm 1 Yes 2 X No	Unknown	t and Number or Rura	Davida Number Ciby
Division o spital or Attending hours after death. neral Director: Aft filled in by the func Certification:	3 Suicide 6 Could not be determined (Specify) Residence	farm, street, factory, office building, etc.		1000 7th S	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/one and manner stated.				
¥ 5 ± 8 <b>∑</b>	29b. Stornature and the of certifier	29c. License number	- 27	d. Date signed (Monti	h, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a	O.C.M.E.	M	ay 29, 2011 —————	
all pents		900 W. Baltimore Street, Baltin	nore, MD 21223		
State Registrar	31. Date filed (Month, Day, Year)  33. Registrar's Signature	parks!			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:38.PM Pearl Timmons AY 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL n/a BALTIMO RE A GNES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec . 23 , 1915 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 95 **Director** 247-26-6370 S. Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, Ira Modical Examinar must be notified at Director Yes 2 No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 115 S. Morley Street 21229 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐Yes 2X No 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Layer Forman Carrlowery Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Ellen McClain ပ Lucas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roslyn Woods (Granddaughter5 Brigade Ct., Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Dulaney Valley 6/6/2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 21. Signature of Funeral Service Licensee Joseph Adress of Brown Jr. Funeral Home, 2140 N. Fulton Ave, Balto., MD 21 bellamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner day ARDIOGENIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Ye aı signed by the a 5 Other (specify) 1 ☐Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t 24a. Was an autopsy performed' certificate 1 ☐ Yes 2. No 1 ☐ Yes : After this certification that the sector, particular to the sector, particular than the sector, particular than the sector of 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 | Yes 2 | 1√10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760 Records, IMMONS **Division of Vital** 

3altimore, Maryland 21215-0036

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificatiely filled in by the funeral director, p 24 hours a completely

29a. Certifie (Check only one)

4 Homicide

29b. Signature and title of certifier

determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MAY 31,2011

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVENUE, BALTIMORE, MD, 21229 DEBERE 31. Date filed (Month, Day, Year)

P25480

State Registrar



within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Betty B. Wigner Physician/ Month <u>0:</u>37₽ м June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Cockeysville Catered Living of Cockeysvill If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 149-12-1899 92 Director DE 05/19/1919 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Cockeysville Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21030 USA 10883 York Road death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc 1 Never Married 2 Married 2 XNo within 72 hours after Yes Maryland 21215-0036 White 1 ☐ Yes 2 A No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Black & Decker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cannon William Viney Betts Bessie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300~W.~Timonium~Rd.,~Timonium,~MD~2109319a. Informant's Name/Relationship (Type, Print) William D. Badore/ POA 300 W. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State Final Journey Crem. 6/8/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota, Marshall 4- Mous 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) earl Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 as the l IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Year Day the P.O. ģ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate Yes 2 W No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29d. Date signed (Month, Day, Year) nd title of ce 29c. License number 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE BALTIMORE MD ATAT N CHARIE ST 4105 KUMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 7 2011 Registrar

DHMH 17 Rev 7/2009

11-04074	
Sarah Wilson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arah Wilson		Sta 1- For State Registrar	ate of Maryla		artment o		Mental i		eg. No.	
Physicia Medical Exami		Decedent's Name (First, Middle		arah	Wils	on		2. Date of Dea Month May 31, 2	th Day Year	3. Time of Death 1343 hrs
		4a. Facility Name (if not institution Johns Hopkins Hospita		mber)		4b. City, Town, or L Baltimore	ocation of Dea		4c. County of	Death
Funeral Director		214-62-7921	6. Sex	7. Age (In yrs. I 58	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24H Hours M	_	10	Birthplace (State or Foreign Country)
Maryland 28a-f show any d at once.	or	Usual Residence of Decedent  10a. State 10b. County  MD		10c. City,	Town or Locat		Baltim	ore	_	10d. Inside City Limits 1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	I Director	10e. Street and Number 415 Nor	th Glove	er Stre	eet	10f. Zip Code 212	224	1	0g. Citizen of Wha	t Country? USA
ē . 5	by Funeral		Armed Formation 1 Yes  Proced If Yes, Give Year  or Dates:	2 🔀 No	1f Y	s Decedent of Hispa es, specify Cuban, I Yes 2 No	Mexican, Puerl	to Rican, etc.)	White, Specify:	Black
36 hin 72 hour te. than "natt	Completed	15. Decedent's Education (Spec Elementary/Secondary (0-12) 1 0	College (1		during m	t's Usual Occupation ost of working life. If ine Ope 1	DO NOT use re		16b. Kind of Busin	·
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Con	17. Father's Name (First, Middle, I Fennie							Maiden Surname)	
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours al nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural other traumatic event, the Medical Examin	ျှ	19a. Informant's Name/Relationsh Tammy Jackso			415		er Str	Rural Route Num eet, Ba	altimore	e,MD 21224
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Special	ecify:	Fin	rematory or oth al Jour	_	. 6/6	Date 5/2011	Woodbin	·
Physician	4	21. Signature of Funeral Service L 23a. Part I. Enter the disease, or of	a lea	rsheat		Marylan PO Box	1413,	mation Baltin	Service nore, MD	25 21203 Approximate Interval
/Medical :xaminer		failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line. a. <b>Pneumor</b>							Between Onset and Death
	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	consequence of						
uted d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a	consequence of	f):					
50, te be execu ysician an	Medical	UNPENDED				918 8-3-1	1 sm		[001 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Box 6876 e death certificate the attending phy ed for use as the b	hysician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unkn	1 Live bi	ant at time of de	2 Fel	al death 3	Ectopic pregr	nancy	23d. Date of de Month	Day Year
res that the signed by the be detached	by P	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause give	en in Part I.			te to the cause of death?  Probably 4  Unknown
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.  Funeral Director: After this certificate has been signed by the attending physician and certified in by the funeral director, page 2 should be detached for use as the burial - trans	Completed							24a. Was a autop: perfor	sy prio med? dea	or e autopsy findings available or to completion of cause of oth?  Yes 2 No
irector.	Be	25. Was case referred to medical examiner?	Hospital: 1 🗸 Ir	patient 2	ER/Outpatient		f Death (Check		D:	
on of V ending Phy ath. or: After th	tion: To	1 V Yes 2 No  27. Manner of Death  1 Natural 5 Pendir	28a. Date of (Month,		28b. Time of Ir	njury 28c. Injury	- Tulis		Residence 6 (	Other:
Division  To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the funeral	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho	ome, farm, stree	t, factory, office buil	lding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
To the Hosp within 24 ho To the Function	ledical C	29a. Certifier 1 Certifying Phy one) 2 Medical Exam	vsiclan: To the best iner: On the basis o and manner st	f examination ar	ge, death occum nd/or investigati	red at the time, date on, in my opinion, d	and place, and leath occurred	d due to the cause at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	¥	29b. Signature and title of certifier	U. pur)			29c. License r			29d. Date signed June 1, 2011	(Month, Day, Year)
Line		30. Name and address of person w Pamela E. Southall, MD				W. Baltimore S	Street, Balt	imore, MD 21	223	

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month 5 James A. Wiley, Jr. June 9:44 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 703 E. Broadway Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1X M 2 - F (Month, Day, Ye Sept 2, Days Hours Min. 63 218-42-8903 Maryland **Director** 1947 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 703 E. Broadway 21014 United States items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black White etc. è by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XXo Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Yes Give 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lab Technician BP Castrol Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James A. Wiley, Sr. Virginia Crampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen P. Wiley / Wife 703 E. Broadway Bel AIr, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 9, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 2011 Parkville, Maryland 21. Signature Juneral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel& Cremation Services-BelAir wid Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph\_sician/ or ornare YPars Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE Live Birth 2 Fetal death nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Por Day Pregnant at time of death Month Year 5 Other (specify) ned by the a e detached fo Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part signed 23e. Did tobacco use contribute to the cause of death? ò be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? disease 24a. Was an Hospital or Attending Physician: The law page 2 this certificate has autopsy performe 1 🗌 Yes 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. 1 Natural 2 Accident 5 Pending (Month, Day, Year) injury work' 1 Tes 2 No Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) πpleted filled in by determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie PO 20011 (Type, Print) 00 21040

DHMH 17 Rev 7/2009

Registrar

Registrar's Signature

11-04161 Wynetta S Wright

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	o m.g.		1- For State	Certificate of	f Death		Reg	g. No.	
F	Physicia		Registrar  1. Decedent's Name (First, Middle,Last)				2. Date of Death Month	Day Year	3. Time of Death
	Exami	ner	Wynetta Shamonta Wright				June 2, 201	<u> </u>	2029 hrs
			4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Temple Hills		th	4c. County of De Prince Geo	
			2300 Oxon Run Drive				m I Poto of Birth		Birthplace (State or
	uneral			(In yrs, last birthday)	If Under 1 Year Months Days			Ea	reign Country) Maryland
D	irector		217-29-1846 1 M 2XF	20 Yrs			06/30/	1990	Country) 2
			Usual Residence of Decedent	10c. City. Town or Locat	ion				10d. Inside City Limits
	w any		10a. State 10b. County MD Baltimore	Windsor					1 Yes 2 No
Pue	28a-f show	ě	N)	***************************************	10f. Zip Code		I 10	g. Citizen of What C	Country?
Many	28a-	Director	10e. Street and Number 8244 Church Lane		2124	4		USA	,
4	3a on						Specify Yes or No-	14 Race - Ar	merican Indian, Black,
4	or items 23a or 28a-f shomust be notified at once.	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	If Y	es, specify Cuban	, Mexican, Puer	to Rican, etc.)	White, et	
2	or it	큔	1 Yes 2 3 Widowed 4 Divorced If Yes, Give Yaar	X No	Yes 2 No	specify:		Specify: I	3lack
d	ural"	ğ	or Dates:  15. Decedent's Education (Specify only highest grade com		nt's Usual Occupat	tion (Give kind o		16b. Kind of Busine	ess/Industry
1	Exa t	ğ	Etementary/Secondary (0-12) College (1-4 or 5	during n	nost of working life	. DO NOT use r	etired)		
36	than cdical	힐	12th	She	eriff Exp	lorer		PG Poli	ce Dept.
0	ygien other	Completed	17. Father's Name (First, Middle, Last)				me (First, Middle, M	laiden Surname)	
21215-0036	ital H	Be	Everett L. Tucker				e Wright		
D 21215-0036	d Mer	ဥ	19a. Informant's Name/Relationship (Type, Print )					ber, City or Town, S MD 2074	
Q S	d 2 sr lth an n 27 i		Everett L. Tucker (Father)	20b. Place of Dispo			Suitland,	20c. Location - Cit	
ē.	s I an of Hea If ite		20a. Method of Disposition  1 XX Burial 2 Cremation 3 Removal from St.	ate crematory or o	ther place)	1			
E	Pages nent of ant: If or othe		4 Donation 5 Other Specify:	Glenwood			·	Washingt	
Baltimore,	permit. Pages I and 2 should be three within 2 thous surer or Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the <u>Medical Examiner</u> mi		21. Surfature of Funeral Service Licensee					neral Ser	
			23a, Part I. Enter the disease, or complications that caused	the death Do not enter	594 Beech	Road;	Temple H	est, shock, or heart	20748 Approximate Interval
	ysician Isaicul		failure. List only one cause on each line.		ato mode or dying.	, 040, 40 14.14.	/ / / / / / / -		Between Onset and Death
	aminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound Due to (or as a cons						<del></del>
				equentes ory.					
		ē	if any, leading to immediate  Due to (or as a cons	equence of):					
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last	equence of):	_				
	scuted and transit	<u>S</u>	events resulting in death) Last Due to (or as a cons	oque:1100 0.7.					
	execut an and al - tra	<u>8</u>	UNPENDED AMENDED						
60	ate be ex hysician e burial	Medical	IF FEMALE: 23c. If yes, outco	me of pregnancy				23d. Date of del	
82	rtifica ing pl as th		23b. Was decedent pregnant in the	=		Ectopic pre	gnancy	Month	Day Year
Box 687	eath certific attending p for use as th	Physician/	1 Ves 2 No 9 Unknown 9 Vnknown	t time of death 5	other (Specify)			Jun 6, 20	010
ă,	the de by the ached fo	چَ		th but not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
O. 9	res that signed b be detact	2					1 Yes	2 V No 3	Probably 4 Unknown
Ś	v requires s been sig should be	Completed					24a. Was		re autopsy findings available r to completion of cause of
Records,	law re has be 2 sho	휼						rmed? dea	th?
æ	certificate ector, page	5			OC Plea	e of Death (Che	1 Yes	2 No 1 V	Yes 2 No
豆	ysician: The his certificate director, page	B B	25. Was case referred to medical	ent 2 ER/Outpatie				Residence 6	Other: Scene
Ξ	Physi x this ral dir		1 Yes 2 No Impati 27. Manner of Death 28a. Date of Inj			ury at Work?		how injury occurred	
0	ding Ph h. After t funeral		1 Natural 5 Pending FOUND: Day;	Year) FOUND:	1	Yes 2 🗸 No	Subject sho	t	
Sio	Attend r death ector: by the	l g	2 Accident Investigation Jun 2, 2011 28e, Place of I	2029 hrs njury - At home, farm, str	reet, factory, office	building, etc.	28f. Location (	Street and Number	or Rural Route Number, City
Division of Vital	tal or rs afte al Dir led in	Certification:	3 Suicide 6 Could not be determined (Specify) W				or Town, S 2300 Oxon R	State) un Drive, Temple	Hills, MD
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director - After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 4 Certifying Physician: To the best of r	ny knowledge, death occ	curred at the time,	date and place,	and due to the caus	se(s) and manner as	s stated.
	thin 2 the I	Medical	(Check only one) 2 Medical Examiner: On the basis of example and manner stated	amination and/or investig	gation, in my opinio	on, death occurr	ed at the time, date	and place, and due	to the cause(s)
	¥.≱ <b>‡</b> §	₹	29b. Signature and title of certifier		29c. Licer	nse number			(Month, Day, Year)
			( Cartenu)		0.0	.M.E.		June 3, 2011	
	,		30. Name and address of person who completed cause of	death (Item 23a)			ND 6 1005		
V	7		Laron Locke MD. Assistant Medical Ex		-	et, Baltimor	e, MD 21223		
	Regi	State	יייי און און לי מיוווייייייייייייייייייייייייייייייי	ar's Signature	Mes.				

11-04163 Jaylin Wright

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ayını vviigin		For State Certificate of	Death	Reg. N	No.	0 2 22
Physician/	_	egistrar . Decedent's Name (First, Middle,Last)		Date of Death     Month Da	Ī	3. Time of Death
Medical Examine	r	Jaylin Wright		June 2, 2011		2053 hrs
	4	a. Fecility Name (if not institution, give street and number)  23rd Parkway @ Southern Avenue	4b. City, Town, or Location of Dea Temple Hills		4c. County of Death Prince George	
Funeral Director		Sociel Security Number 6. Sex 7. Age (In yrs. last birthday)		in. 06/06/20	010 P. Birtl O10 Cou	ntaylaryland
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 23a-f show any or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		1 Never Married 2 Married 1 Armed Forces? No 1 Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  17. Father's Name (First, Middle, Last)  Richmond Phillips  19a. Informant's Name/Relationship (Type, Print)  Nyvette Wright (Grandmother)  20b. Place of Disposition  1 Name/Relation 3 Removal from State  College (1-4 or 5+)  Armed Forces? No 1	r Mill  10f. Zip Code 21244  as Decedent of Hispanic Origin? ( fes, specify Cuban, Mexican, Puer Yes 2 X No specify:  nt's Usual Occupation (Give kind of lost of working life. DO NOT use not of working life.	Specify Yes or No- to Rican, etc.)  of work done etired)  me (First, Middle, Maid a Shamonta or Rural Route Number	Wright r, City or Town, State, Maryland Oc. Location - City or	zan Indian, Black,  aCk  Idustry  Zip Code)  1 21244  Town, State
Baltimore, permit Pages I at Department of Her in Important: If ite injury or other ir	2	4   Donation 5   Other Specify: 21 Sun ture of Funeral Service Licensee 22.	Name and Address of Facility Fr. 94 Beech Road;	Temple Hil	ls, MD 20	
Division of Vital Records, P.O. Box 68760, To the Haptial or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Financial Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Examine	past 12 months?	er me, g916 6-15  etal death 3 Ectopic presenter (Specify)		23d. Date of deliven Month [	y Day Year
Division of Vital Records, P.O. Be tall or Attending Physician: The law requires that the de tall of the dear death.  1 Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached for the dear	ompleted by Pny	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 Yes  24a. Was an autopsy	24b. Were au	the cause of death?  pably 4 Unknown  topsy findings available completion of cause of
BCO te law te has ge 2 sl	티			performe	ed? death? No 1 ✓ Yo	es 2 No
II Re	⊩ د	25. Was case referred to medical	26.Place of Death (Che			
Vita	Ö	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other Nu		esidence 6 🗸 Othe	
on of anding Physics After the funeral	- h	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Particular Section 1. 1 Pending	1 Yes 2 X No	28d Describe ho to enclosed temperature	winjury occurred sul lauto in hot es	oject confined environental
Division Attention and Intercept to Attention	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Parking 1ot		28f. Location (Street Town, State Temple H	eet and Number or Ru te) 23rd parkwa [ills,Md.	ral Route Number, City y@Southern Ave
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one)  2 Medical Examiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ation, in my opinion, death occurre	and due to the cause(	s) and manner as sta	ed.
	Me	29b. Signature and title of certifier	29c, License number O.C.M.E.		29d. Date signed <i>(Mo</i> June 3, 2011	nth, Day, Year)
or prov		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. E	Baltimore Street, Baltimore	e, MD 21223		
Sta Registr	_	24 Data filed (44 - 45 Day Year) 32 Penistrat's Signatures	ald			
r (egisti)	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 1 per dr., g923,01/13/2012dhb

Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jesse Bernart White Sr. Month Physician/ 26 Medical or Location of Death Name (if not institution, give street and number) Examiner 8. Date of Birth (Month), Day, g. Birthplace (State or Foreign **Funeral** Country) 🛭 2 🗆 F Months MD 214-84-4070 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location. 10b. County 10a. State Director N/A 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 No Specify: 1 Yes 2 XNo
If Yes, Give
Year or Dates. 1 Never Married 2 Married 3 Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry 12. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Worker Construction 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Loiuse Phillips Be 17. Father's Name (First, Middle, Last) Howard Lee White, Sr. 2 19a. Informant's Name/Relationship (Type, Print)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102
Christine L. Marshall/Sister 5334 Carroll Warehime Rd. T. ineboro MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory of other place)
Cedar Hill Cemetery XX Burial 2 Cremation 3 Removal from State 6/1/11 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ture of Eunoral Service Licensee Victor Doda Charles L. Stevens Fun 1501 East Fort Avenue, Stevens Funeral Home, Inc Fort Avenue, Baltimore MD Approximate real Between and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) 14 hours Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IE EEMALE 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 2 No detached is been signed by the should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 20 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 perform Vas 2 26. Place of Death (Check only one) **Division of Vital** funeral director, 25. Was case referred to medica Be examiner? 1 X Yes 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending tall From Roo 5/28/1/ 28e. Place of Injury - A building, etc. (Spe 1 Yes ithin 24 hours after death.

the Funeral Director, Al
pmpleted filled in by the fu 2 Accident Investigation 0 28f. Location (Street and Number of Rural Route Num City or Town, State) #100 ( ) Street Bulnman, MD 3 ☐ Suicide 4 ☐ Homicide 6 Could not be iry - At home, farm, street, factory, office c. (Specify) determined Single family Home #100 Constitutions, ND 21
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar

DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ialla

31. Date filed (Month, Day, Year)

0 7 2011

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Registrar

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day STEPHANIE YVETTE CLARKE WILLIAMS JUNE 2011 2131 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 M 2 🔀 F Days Hours July 17, 1966 Yrs 44 MD Director 213-96-7214 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No MD Prince Georges College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9202 Davidson St. 20740 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. "natural", or Completed by 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 12thReal Estate Investor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ည Henry L. Clarke Carolyn A. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) College Park, MD. 20740 9202 Davidson St. Arnold Williams - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 6-13-2011 Alexandria, VA. 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Marshall—March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final CARDIOM Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Exam that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 K No To the Hospital or Attending Physician: <sup>1</sup> within 24 hours after death. To the Funeral Director: After this certifics within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 2 X No 1 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2-011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keller MD7901 Maple Ave TAKOMA PARK, ND 20912 remore

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

of Vital

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G916, 6/7/2011, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 3. Time of Death 10:24 P<sub>M</sub> 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Jume 1, 2011 Physician/ Mary Elizabeth Walpole Medical County of Death Harford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Abingdon 2717 Parallel Path 8. Date of Birth (Month, Day, Year) Dec. 10,1932 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗚 Months Maryland 78 Dec. Director 212-30-5442 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 1 🗆 Yes 2 No Dover Delaware | Kent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō must be r Funeral 19901 19 Drew Court USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Examiner Black, White, etc. ō 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural" 3₺ Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname)
Marie (unk) Yuhn 17. Father's Name (First, Middle, Last) 2 Marie Theodore P. Toulan Funeral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael J. Ambruso F.H. Birecton State St., Dover, DE 19901 1175 S. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 K Removal from State 4 Donation 5 Other (Specify) 6-9-2011 Dover, DE Cross Cemetery permit. McComas Funeral Home, P.A. 21. Signature of Funeral Service Lig 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or compensations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) the the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? preem 24a. Was an cate has page 2 s autopsy performed 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Daughter's Residence Be Hospital: Other: 4 Nursing Home 5 Residence 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.

Funeral Director: After the eted filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death monium 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Davs Hours Min (Month, Day, Country) **Director** Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2226 2122 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? /
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married δ 1 Yes : Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12Th ort Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21223 a Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremater une 10,2011 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ PANCREATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death EDWARD WATSON the 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Completed director, page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES. CRNP TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 11-04059

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ernon Watkins		State of Maryland / Department of Health and Mer -For State Certificate of Death		eg. No.	0	18034
Physician		(egistrar 1. Decedent's Name (First, Middle,Last)	Date of Dea     Month	Day	Year 3.	Time of Death 1631 hrs
ledical Examin	er	Vernon Leroy Watkins	May 30, 2		ounty of Death	10311115
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location  Baltimore			N/A	
Funeral		S. Social Security Number			YYYY) 9. Birthp Foreign	MD
Director		219-52-7453 <sub>1 Months</sub> Days Hour	rs Min. 9/22,	/1948	3 Count	try) MD
any	- 1-	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location			1	Od. Inside City Limits
ě		MD N/A Baltimore			1	Yes 2 No
aryland Sa-f show at once.	Director	10e. Street and Number 10f. Zip Code		0g. Citizen	of What Country	n
th the Maryland 23a or 28a-f sho		934 E. Biddle Street 21202			JSA	f a Diad
th with	Ē L	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Or  14. Was Decedent of Hispanic Or  15. Was Decedent of Hispanic Or  16. Yes, specify Cuban, Mexical	rigin?(Specify Yes or No ın, Puerto Rican, etc.)	)- 14.	Race - America White, etc.	n Indian, Black,
er dea	-	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify	y:	Sp	ecify: Bla	ack
vurs aft	9	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give during most of working life. DO NO	e kind of work done T use retired)	16b. Kind	of Business/Ind	ustry
6 1 72 hc	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)			N/A	
within giene.	<b>E</b>	12th N/A unemploy  17. Father's Name (First, Middle, Last) 18. Mothe	er's Name (First, Middle,	Maiden Su		
21215-0036 Juld be filed within 72 hours after death with the Maryland I Mental Hygiene. I marked other than "natural", or items 23s or 28s-fah ic event, the Medical Examiner must be notified at once	8	Icham Watkins Cor	nelia Sta			
2 a g g g	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Nu				
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	-	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date Date	20c. Loc	cation - City or To	own, State
DOFE Iges 1 at of H t: If it	- [	1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemt.	6/6/2011	Bal	timore	, MD
Baltimore, permit. Pages I an Department of Hea Important: If itee	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facilities	March F	H I	101 E.	North
Per Per III	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as			or heart	Approximate Interval
Physician Medical		failure. List only one cause on each line.				Between Onset and Death
Examiner	-	$\begin{array}{llllllllllllllllllllllllllllllllllll$	diovascular	DISC	ase	
	_	Sequentially list conditions, If any leading to immediate  Due to (or as a consequence of):				
	miner	cause. Enter Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):				
xecuted n and - transit	Exa	d				
0, be executed sician and burial - transi	edical	▼ UNPENDED	-24-11 sm			
	2	IF FEMALE: 23b. Was decedent pregnant in the 2ctor 1 Live birth 2 Fetal death 3 Ector	pic pregnancy		Date of delivery onth Da	y Year
Box 6876( death certificate the attending phy.	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
the dea	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I	Part I. 23e. Did	tobacco us	e contribute to th	ne cause of death?
ires that the signed by 1	2	Chronic Alcohol Use, Intravenous drug abuse		es 2 🗸 l	No 3 Proba	bly 4 Unknown
rds, requir been s	etec			psy	prior to co	ppsy findings available mpletion of cause of
Vital Records, ysician: The law requiins certificate has been to director, page 2 should	Completed			ormed? 2 No	death? 1 ✔ Yes	2 No
tal Rection: The certificate ector, page	Be C	20, Yes day received to measure	th (Check only one)	] p:4	ce 6 Other:	
f Vid Physic er this	မ	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA  Orner4  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at Wo				
on of adding Plath.	tion:	1 Natural 5 Pending (Month, Day, Tear)				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the b	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, (Specify)	etc. 28f. Location or Town,		Number or Rur	al Route Number, City
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and more)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	place, and due to the ca occurred at the time, da	use(s) and e and place	manner as state e, and due to the	d. cause(s)
To with To COT.	Me	29b. Signature and the of certifier  29c. License numb	per		ate signed (Mon	th, Day, Year)
		Tille Salle Salle O.C.M.E.		June	1, 2011	
		30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD 21	223		
St	ate	31. Date filed (Month, Day, Year) 3. Registrar's Signature	· · · · ·			
Regist	rar	, comment of the same of the s			·	
DHMH 17 Rev 1/2	001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Laverne Wedeme		1- For State	tate of Maryla		ertificate o		d Menta	Hygi		eg. No. 20	A Property	12035	
/ Physicia	ın/	Registrar  1. Decedent's Name (First, Middle, Last)							Date of Deal	h Dav Yea	ır	3. Time of Death	
Medical Examir	ner	Laverne T. Wedemeyer May 31, 2011  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death								of Death	1553 hrs		
		Baltimore Washingto		-		Glen Burnie				Anne Ar			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year		4Hrs. 8. Min.	Date of Bir	th (MM/DD/YYYY	Foreig	n	
Director		212-30-8596	1 M 2 X F	77	Yrs		s Hours		06/04	/1933	Cou	<sup>untry)</sup> Maryland	
Any	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Locat	ion	_					10d. Inside City Limits	
▶	۲	Maryland Anne Arundel Pasadena									1 Yes 2 No		
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What								nat Cour	ntry?		
h the ? 23a or		722 222nd Street 21122							U.S.A.				
ath wit	Funeral	11. Marital Status  1 Never Married 2 N	edent Ever in I	J.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto)									
fter de		3 Widowed 4 Di	1 Yes vorced If Yes, Give Year	2 X No	1	Yes 2 No	specify:			Specify:	Whi	te	
natura	od be	15. Decedent's Education (Spe				nt's Usual Occupa			done	16b. Kind of Bu			
36 in 72 h	plet	Elementary/Secondary (0-12)		-4 or 5+)						N 1		1	
5-0036 led within 7. Hygiene. other than	Completed	17. Father's Name (First, Middle	N/A		<u> </u>	Personne	18. Mother's N	ame (Fir	st, Middle, N	Nava1		demy	
215 be file ntal Hi rked o	Be	Frank	Α.	Szyı	manski		Rose		A	•	Су	ganiewicz	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f abo injury or other traumatic event, the Medical Examiner, must be notified at once.		19a. Informant's Name/Relation		- `	P. P.	g Address (Stree						, ,	
and 2 ::	ŀ	Eric M. Wedeme 20a. Method of Disposition	yer, Sr. (		835 T Place of Dispos	eering F	Road Pa	<u>sade</u> Da	<u>na. M</u>	aryland 20c. Location -	211 City or	22 Town, State	
DOFE ages 1 nt of H it: If i	1	1 Burial 2 Crematio			crematory or ot	herplace) en Mem. F	ole O	6/00	/2011	Clar D	ımni	e, Maryland	
altin mit P partme	1	4 Donation 5 Other S 21. Signature of Funeral Service		10.	22. N	lame and Address	s of Facility					e, Haryland	
E E P E	-	15h-3	7 bellen			lcCu11y-F 204 Mour	olynia itain R	k Fu oad	neral Pasad	Home, l ena. Mai	ovla	nd 21122	
Physician /Medical		23a. Part M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Internet Between Onset are											
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Death  Due to (or as a consequence of):											
	.	Sequentially list conditions,  b											
bd sit	Xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
O, e be executed sician and burial - transit	dical Examiner	d. UNPENDED AMENDED											
	<b>•</b> -	IF FEMALE:	23c. If yes, c	outcome of pre	gnancy					23d. Date of	delivery	1	
Sox 6876( death certificate te attending phys	ian/	23b. Was decedent pregnant in t past 12 months?	I I I I I I I I I I I I I I I I I I I	rth ant at time of d		tal death 3	Ectopic pre	gnancy		Month	D	ay Year	
Division of Vital Records, P.O. Box 6876( the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Fuoeral Director: After this certificate has been signed by the attending phy. physicial in by the funeral director, page 2 should be detached for use as the b	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown											
P.O. B. that the de med by the detached f	by P	Part II. Other significant condi	tions contributing to	death but not	resulting in the u	inderlying cause (	given in Part I.	Ĭ				the cause of death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  In Director: After this certificate has been signed by the funeral director, page 2 should be detach.								-				ably 4 Unknown	
Vital Records, vaician: The law requii	Completed		24a. Was an 24b. Were autopsy find autopsy prior to completion performed? death?										
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/ital		25. Was case referred to medical 26. Place of Death (Check only one)  examiner?   Hospital:   Institute   2   Institute   2											
n of \ding Phy		27 Manner of Death 28a Data of Injury 28h Time of Injury 28c Injury at Work 2 28d Describe how injury occurred										nmental	
ivision lor Attendi after death. Director:	iati)	1 Natural 5 Pending Investigation Pound: 1453 hrs Pound: 1 Yes 2 No Subject exposed to high environmental temperatures											
Divisior pital or Attendours after death orral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family Home 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) 772 222nd Street, Pasadena, MD									ral Route Number, City		
Hospit 14 hour Fuoers		29a. Certifier , Cartifier , Cartifier To the best of my knowledge death accurred at the time date and place and due to the accuracy and manner as stated											
Division  To the Hospital or Attention 24 hours after death within 24 hours after death To the Fuoeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Ĭ	29b Signature and title of certifi				29c. License number						(Month, Day, Year)	
	4	() Cause	my)			O.C.	W.E.			June 1, 20	11		
l	ľ	SQ_Wame and address of person Laron Locke MD. A	who completed cause Assistant Medical			ıltimore Stree	t, Baltimor	e, MD :	21223				
Sta	ite	31. Date filed (Month, Day Year)	37. Re	gistrar's Signat	ture								
Registr	ar	<u> </u>	011	m p	. por								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 state of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 💪 3:10 Physician/ Day 4 Year PM Webb N. Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** af Bu Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Z F Hours (Month, Day, Year) 213-30-8047 Director 1933 Virginia Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Pasadena 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? should be filed within 72 hours after death with the and Mental Hygiene.
I is marked other than "natural", or items 23a or rammatic event, the Medical Examiner must be Funeral 10th Street 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify If Yes, Give 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 N/A Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Smith **Aline** Price or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 strength a Health a tant: If item 27 i George H. Webb (Husband) 10th Street Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 06/09/2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. <u>3204 Mountain Road Pasadena.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ 1etastah; overran disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be P.O. Box 68760 nding p as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter for u in the past 12 months?
1 ☐ Yes 2 ☒ No Year Month Day 5 Other (specify) Pregnant at time of death s been signed by the s should be detached 1 U Yes 2 2 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given i*n* Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

On the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 s. autopsy performed? Yes 2 N N After this certificate has funeral director, page 2: 1 Yes 2 No 25. Wa case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ဂ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 071488 12011 - Motameru MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drine. Hen Burnie, mo 2016! 301 Hospital Neda Motamera 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

webb

11-03896 William Ward

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

William Ward		State of Maryland / Department of For State  - For State Certificate of Certifica		Re	g. No. 20	11 1803.
Physiciar Medical Examin	-	1. Decedent's Name (First, Middle,Last) WILLIAM K. WARD		2. Date of Death Month May 24, 20	Day Year	3. Time of Death 1832 hrs
		4a. Facility Name (if not institution, give street and number) N/B Baltimore Washington Pkwy S. of Goodluck Rd.	4b. City, Town, or Location of Death Riverdale		4c. County of D Prince Geo	
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. 78 - 08 - 2506 1 M 2 F 34 Y	If Under 1 Year If Under 24Hrs Months Days Hours Min	_		Birthplace (State or Country)WASH., D
5-0036 led within 72 hours after death with itygene. to deter than "natural", or items 23, the Malical Examiner must be no	Completed by Funeral Director	1 Never Married 2 Married   Armed Forces?   If Yes 2 No   No   No   No   No   No   No   No	ON  10f. Zip Code  20011  Vas Decedent of Hispanic Origin? (Sives, specify Cuban, Mexican, Puerto  Yes, Specify Cuban, Mexican (Give kind of most of working life. DO NOT use ret  DRIVE	pecify Yes or No- Rican, etc.)  work done ired)  R R	White, et specify: B I 16b. Kind of Busine PRIVATI laiden Surname)	STATES merican Indian, Black, tc.  LACK pss/Industry
more, MD 2121; Pages I and 2 should be fill then of Health and Mental I nearly if item 27 is marked or other fraum 21 is marked	TO Be	SANDRA WARD/WIFE 21  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Crematory or Crema	ng Address (Street and Number or I 3 VARNUM ST NW position (Name of cemetery, other place)	WASHI	ber, City or Town, S NGTON, I 20c. Location - Cit	OC 20011 y or Town, State
Baltim permit. Pa Departmen Important injury or	-	21. i sure of Funeral Service Licensee 22.	Name and Address of Facility APA 425 MARYLAND A	TICL M	RTUARY	NGTON, D.C. NGTON, DC
Physician /Medical -xaminer	miner	23.* Part I. Enter the seef e, or complications that caused the def Do not enter failure. List only in a cause on each line.  Immediate Cause (Fin II disease or condition resulting in death)  Sequentially list conditions, ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	the mode of dying, such as cardiac c	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
3760, ficate be executed g physician and sthe burial - transit	edical	d.  UNPENDED  AMENDED  FEMALE: 3b. Was decedent pregnant in the	etal death 3 Ectopic pregna	ancu	23d. Date of del	ivery Day Year
Box 6876  Re death certificate the attending phy led for use as the burners.	Pnysician/M	past 12 months?  1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 0	Other (Specify)			
s that	Completed by	Part II. Other significant conditions contributing to death but not resulting in the		1 Yes  24a. Was a autops perforr  1 Yes 2	2 No 3 24b. Were prior ned?	e to the cause of death?  Probably 4  Unknown  e autopsy findings available to completion of cause of h?  Yes 2 No
Vital ysicians this certi	900	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check  ont 3 DOA Other Nursin	· · · · ·	Residence 6 🗸 0	ther: Scene
Division of Vi To the Hoppial or Attending Physis within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director		27. Manner of Death 1  Natural 5  Pending	1 Yes 2 ✔ No		ow injury occurred er of vehicle inv lent	volved in motor
Division of the Hoppial or Attending him 24 hours after death. the Funeral Director: Aft upletely filled in by the funeral Castefication:		Suicide  Could not be determined  Specify  Speci	у	or Town, St N/B Baltimore	ate) Washington Pkw	r Rural Route Number, City y S. of Good, Riverdale,
To the H within 24 To the Fr completel	8 <u>0</u> -	Check only  2 Medical Examiner: On the basis of examination and/or investig and manner stated.				
		9b. Signature and title of certifier  Leol. H. King Thymus D.	29c. License number O.C.M.E. OCM	AE .	29d. Date signed May 25, 2011	(Month, Day,Year)
Di.		10. Name and address of pers 11 who complet 11 case of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner	900 W. Baltimore Street, B	altimore, MD	21223	
Stat Registra	_	1. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month () 0810 201 JAILENE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Tate Hospice House Linthicum Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 37 Hours 296-30-8347 74 Jan. **Director** Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Yes 🔊 No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a 115 Severn Way 21012 U.S.A. items 2 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed CreativeBarterNetwork Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Smo1ka Annabelle Saunders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taralynn A. Schmidt 1661 Secretariat Drive, Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite Date any injury or 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) cremation, Inc. cremation, Inc.: 6-3-11 Hanover, Maryland
22. Name and Address of Facility Marzullo Funeral Chapel, F.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or linjury that initiated events resulting in death) Last ending physician and use as the burial-tran Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be ex Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknow Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 After this certificate has autopsy performed 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and Atle of cert

State Registr<u>ar</u> who completed cause of death (Item 23a) (Type, Print)

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Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month\_ Year Day Physician/ LDAED 201 HOUISE Medical 4b. City Jown, or Location of Death Eacility Name (if not institution, give street and number, 4c. County of Death **Examiner** pice of 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex . Age (In yrs. last birthday) 8 Date of Birth **Funeral** Days Months Hours Month Day Cara 3 1 □ M 2 🔼 F Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1. Yes 2 ☐ No ALIS BURS MD WICOMICO 10g. Citizen of What Country? 10e. Street and Number Funeral SCHUMAKER Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215,0036 1 ☐ Yes 2 HNo Specify: If Yes. Give Specify: WHITE Completed Year or Dates. 16b. Kind of Business Industry 15 Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DELMATVA POWER ECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GELLLANDE AINGENT HATTY MURPHY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ELLI COTT-CITY, MD 21042 PAUL ANDERSON (SOM ARJAY CIRCLE 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date SAUSBURY, MID 4 ☐ Donation 5 ☐ Other (Specify) 41814 21. Signature of Funeral Service Licensee

2. Name and Address of Facility

C34FnnRouckt MC0446

MESSUKFUNERAL HOME PO

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 2. Name and Address of Facility MESSICKFUNERAL HOME POBOXGI BIYAWEMID Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Careenoma Ulmare Physician/ years Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year cate has been signed by the a page 2 should be detached t a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🔏 No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cher (Specify) ျ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Certificate: work? 1 X Natural 5 Pending 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 KC Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and on investigation, many operations and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 05-15-2011 D 29505 O. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5302 BELLOSO CHINABERRY DR., SALISBURY, GREGORIO Registrar

Amended #23a 05/17/11, pe		), nls, Pleas	e Type or Pri										18010
	1	State Registrar  Decedent's Name (First, Middle, L	act)		Cer	tificate	of D	eath	_	2. Date of De	Reg. No.		3. Time of Death
Physician/	/	James	asij	Arn	one					Month	Day	2011	2327 M
Medical Examiner		a. Facility Name (if not institution, g	ive street and number)	21211	One	4b. City, To	wn, or	Location of	Death		-	ty of Deat	-10/0
		Western MD Regiona	l Medical Cente	r				Cumbe			Alle	gany	
Funeral Director		220-16-6212	Sex 7. Age 1	86 (In yrs. la	st birthday) Yrs.	If Under 1 Months	Year_ Days_	If Under 2 Hours	Min.	8. Date of Birl (Month, Da Octobe		9, Birt Cot <b>M</b> 8	hplace (State or Foreign intry) <b>rryland</b>
od .	- 1-	Jsual Residence of Decedent  0a. State 10b. County		10c. City	, Town or Loc	cation							10d. Inside City Limits
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ampoints or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	200	Maryland Alleg	any	Fre	stburg								1 ☐ Yes 2 🔀 No
ith the	<u>a</u>	0e. Street and Number 19802	National Hwy			10f. Zip C					10g. Citizen o	if What Co	untry?
ems (		Marital Status	12. Was Decedent E	ver in U.S	. 13. V	Vas Deceder	nt of His	spanic Origi	in? (Spec	ify Yes or No-	14. R		rican Indian,
tter de amine	3	1 Never Married 2 Marrie				f Yes, specify			Puerto P	dicari, etc.)	Speci	lack, White	
21215-003 ifthin 72 hours at leine. r than "natural" the Medical Ex	200	3 X Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates.	1NT		lent's Usual (						W	
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212 within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5	+)	Lette	Carrier					US Pos	tal Ser	vice
and 2		7. Father's Name (First, Middle, Las	et)								Maiden Surna	me)	
uld be und be marke	-	Michael Arnone	T Dist		T				Fabb		61 T	04-4- 70	0-4-1
Mal 2 sho 1th and 27 is r traun		19a. Informant's Name/Relationship James Amone	self			ng Address (S <b>Vational F</b>		and Number		tburg	er, City or Town <b>Ma</b>	, State, 21) ryland	21532-
Te, 1 and if Heal item	1	20a. Method of Disposition	_	20b. Pl	lace of Dispo	sition (Name	of	o)		ate	20c. Locatio		Town, State
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o my niury or other traumatic event, the Medical Examples. To Be Completed by		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			aint Mich				Ma	y 19, 2011	Frostbu	rg	Maryland
Balt permit Departi Import any inji		21, Signature of Funeral Service Lice	ensee	/	22	Name and				Front Asse	, Frostbur	w MD	21532
	+	23a. Part 1. Enter the disease, or co	Akutuf	I the death	Do not ente							g, MD	Approximate
200		shock, or heart failure. List onl	y one cause on each line	Э.				g, 50011 a5 0	a a a a	roop, atory a			Interval Between Onset and Death
Pnysician/ Medical	Ì	disease or condition resulting in death)	a. Due to (or as	Consequ	ence of):	SHOC	K					-	
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certification of the second of		F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnar	ncy 1 death 3 F	Ectopic pre	eananc	:V				Date of de	
Division of Vital Records, P.O. Box 68760 ral or Attending Physician: The law requires that the death certificate be estafter death.  al Director: After this certificate has been signed by the attending physicia of in by the funeral director, page 2 should be detached for use as the burn Contificate. To Be Completed by Dhysician/Medical	200	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Other (spec		, , , , , , , , , , , , , , , , , , ,			'	Month	Day Year
at the d by t letach		Part II. Other significant condition	s contributing to death b	ut not resi	ulting in the u	ınderlying ca	use giv	en in Part I.		23e. Did 1	obacco use co	ontribute to	the cause of death?
S, P	בי מו	METABOLIC	ENCE	RHA	LO PA	THY				1 🗆	Yes 2 No	3 <del></del>	robably 4 🗌 Unknown
Records, P. The law requires the cate has been signed page 2 should be described by	ale le	HIPER				. ,				24a. Was	an 24	b. Were au	topsy findings available completion of cause of
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ivision of or Attending Parter death. Director: After tin by the funera	are	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of inju (Infonth, Da		28b. Time of injury	1	c. Injury work	yat :? Yes 2. <b>∑</b> X	2	28d. Describe	how injury occ		
Siol Attendar r deat ctor:	Ĭ	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of Inju	ury - At ho	me. farm. str		_	7		28f. Location (	Street and Nur	nber or Ru	ral Route Number
Divi		4 - Homicide determin	ed uilding, etc	Specify,	)					City or Too	wn, State	A110.	VAL LIVE!
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be example to the Funeral Director. After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Modical Certificate. To Re Completed by Physician Modical	2010	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of e	xamination	and/or inves	tigation, in m	v opinio	on, death oc	curred at	the time, date	and place, and	due to the	cause(s) and manner stated.
uithin 2 the gathe gathe gathe		only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practioner To the	best of my	Pricwledge -			e time date e number	and plan	n, and due to th	29d. Date sig		
5782		PSUPHEER	SANIKON	1110				973	7		_	1151	
74	-				23a) (Type, F			. , , ,		- 10			
REIDIK.	_	30. Name and address of person when the same same same same same same same sam	Kommu	12	502	Wille	ow	BROO	KY	d (ill	nberl	ANd	MD 21502
State Registrar	-	31. Date filed (Month, Day, Year) NAY 17 201	32. Registr	ar's Signat	far.	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per FH G916 6/16/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:00A M ackwel May 2011 orinne /Medical 4c/County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner aston 0/607 Par 1929 Year) 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 17-28-7. Age (In yrs. last birthday) **Funeral** Days Min. 213-24-0864 1 M 2 F Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "Malfall Evat, Inc., unt. b. putilisatione. 10a. State 10b. County 1 Yes 2 □ No Director a On Talbot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 60 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1∐Yes 2∭2MÎo Specify Black Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veni ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD.21643 Arrowhead sheila HUrlock 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8 Wood awn Cenetery!
22. Name and Address of acility Easton, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry Funeral Home, P.A. 510 Washington St. Cam MD.21613 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Vear 5 ☐ Other (specify) ☐Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No this certificate 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 24 hours after death. e Funeral Director; After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signaturé 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

11-04064 Seth Edward Be			pe or Print i ate of Maryl	and / D	epartment	of He	alth an				egib	le. 20	Berry Co.	1301
		Registrar  1. Decedent's Name (First, Midd	(-1)		Certificate	or De	atn			2. Date of De	Reg. N	0.	× 1	3. Time of Death
Physicia Medical Exami		Seth Edward E	Sennett			1 2				Month May 31,	Day 2011			1115 hrs
		4a. Facility Name (if not institution 4828 Briscoe Road	on, give street and n	umber)			iy, rown, o int Leon	r Location of ard	of Death			4c. County of Calvert	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday		Inder 1 Yea		er 24Hrs.	8. Date of	Birth (M	M/DD/YYYY)		place (State or
Director		414-45-3212	1XM 2F	3:	3	Yrs. Mo	onths Day	ys Hours	Min.	03/2	7/19	978	Foreign Cour	ntry) VA
	ŀ	Usual Residence of Decedent												
# any		10a. State 10b. County		10c.	. City, Town or Lo	cation							- 1	10d. Inside City Limits
land f sho	ğ	MD Calv	ert	S	t. Leona						10.0			1 Yes 2 X No
he Maryland or 28a-f show	Director	10e. Street and Number	,				Zip Code					ditizen of What nited		
ith the	등	4828 Brisco Ro	12. Was De	cedent Ever	rin U.S. I 13		20685		nin? (Spe	ecify Yes or I				an Indian, Black,
eath w	Funeral	1 X Never Married 2 M						n, Mexican,				White,		,,
after d	by F	3 Widowed 4 Div	vorced If Yes, Give Ye			Yes	2 X No	specify:				Specify:	Whi	te
hours :	8	15. Decedent's Education (Spe	cify only highest gra					ation (Give I			16b	. Kind of Bus	iness/In	dustry
36 in 72 l	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)			ng Ag			,		Plumbi	ng S	Supply
-00; d with grene ther t	ē	17. Father's Name (First, Middle	, Last)						's Name	(First, Middle		en Surname)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be	Stephen E. Ber	nett					Rol	bin (	Courto	is			
21 nould I	ဥ	19a. Informant's Name/Relations										City or Town		
MD nd 2 sho alth and arm 27 is	123	Stephen E. Ber 20a. Method of Disposition	nett / H	ather	20b. Place of Dis				Dr.	, Ooth Date		h, TN		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 X Cremation	n 3 Removal f	rom State	crematory of	other pla	ace)	япесегу,						
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Bal Bermi Depar Impo injur		Garry J. Got										MD 20		ert, P.A.
Physician		23a. Part I. Enter the disease,	complications that	caused the d										Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease	TT 1 4	rmine	d									Between Onset and Death
ZXAIIIIIGI	- 1	or condition resulting in death)	Due to (or as	a conseque	nce of):									
	ᅵ	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	nce of);									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.											
tecuted and transit	Exa	events resulting in death) Last	Due to (or as a	a conseque	nce of):								22	
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60, ate be ohysici	Med	IF FEMALE:	23c. If yes,		pregnancy		-		-		12	23d. Date of o	delivery	
ox 68760, eath certificate be ex attending physician for use as the burial	Physician/Medic	23b. Was decedent pregnant in t past 12 months?	I . C. rive	birth nant at time	of death	Fetal dea		Ectopic	c pregnar	ncy		Month	Da	y Year
Sox leath c	ysic	1 Yes 2 No 9 Un			5	Other (S	Specify)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		Part II. Other significant condi	tions contributing t	o death but	not resulting in th	e underly	ing cause	given in Pa	art I.	23e. Dio	tobacc	o use contrib	ute to th	e cause of death?
ires th	d b									1 🗆 Y	'es 2	No 3	Proba	bly 4 🗹 Unknown
ords v requi	Jete									24a. Wa aut	is an opsy			psy findings available mpletion of cause of
RecC The laverate has bage 2	Completed								<del></del>	per 1 ✓ Yes	formed 2		eath? Yes	2 No
in: 1	8	25. Was case referred to medica examiner?				_	26.Plac	e of Death	(Check o	nly one)	-			
of Vit ing Physic After this c		1 ✓ Yes 2 No		Inpatient			DOA	Other <sub>4</sub>				dence 6	-	Scene
ding J		27. Manner of Death  1 Natural 5 Pen	dina	h, Day Year)	28b. Time	•		uryatWork Yes 2∑X	ING	_		njury occurre	a	
Sio	Certification:	2 Accident Inve	stigation 10 3	-31-1 ce of Injury	1 Unkno At home, farm, s					Unknow 28f. Location		t and Number	r or Rura	al Route Number, City
Divi	E E		ld not be	Resi	_		,	ouraling, ou		or Town Saint	State)	4828 P	ris	coe Rd.
Divisior Hospital or Attend 24 hours after death Funeral Director:		29a. Certifier 1 Certifying P	hysician: To the be						ace, and o	due to the ca	use(s)	and manner	as stated	I.
Division of N To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one) 2 Medical Exa	miner:On the basis and manner:	of examinat	tion and/or invest	gation, in	my opinio	n, death oc	curred at	the time, da	te and p	olace, and du	e to the	cause(s)
F 3 F 3	ž	29b. Signature and title of certifi	er /				29c. Licens					d. Date signe		h, Day, Year)
		ling	W	1			O.C.	.M.E.			Ju	ine 1, 201	1	
100)		30. Name and address of person	who completed cau ant Medical Exa			ore St.	reet Dal	timore A	MD 212	223				
aku I	ate	Ling Li, MD Assista 31. Date filed (Month, Day, Year)		gistrar's Si			Dal		VID 2 12					
Regist				enewa		ark	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lee Bittner James Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Allegany 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Cumberland . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Min (Month, Day, Year) 06/28/1943 213-40-4181 67 Marvland Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Allegany Cumberland MD 28a-f 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code 21502 Funeral 230 New Hampshire Avenue items 23a death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: Completed Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Tire and Rubber Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bittner Olive Combs Walter Earl Wanda pe and 2 should b Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 New Hampshire Avenue, Cumberland, MD 19a. Informant's Name/Relationship (Type, Print) Jacqueline L. Bittner / Wife permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other t. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Restlawn Mem. Gardens 05/20/2011 LaVale, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Sen 404 Decatur Street, Cumberland, MD 21502 Part 1. Sofer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ CARDIDGENIC disease or condition Medical resulting in death) Examiner MUCARDIAL INFALCTION) ON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? detached for Month Year 5 Other (specify) the g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accid-5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Negretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated at Certifying Nurse Pacific Per To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number Date signed (Month, Day, Year) 0025 av 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Lamm, M.D., 12500 Willowbrook Road, Cumberland, MD 21502 nas 31. Date 14 (1901) 8y. 2011

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 19 .°2011 5:40 AM Russell Barnhart James Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 17115 Maniford Road Oldtown Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Month, Day Ye Director Yrs 214-62-4760 59 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ä Director 10d. Inside City Limits within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Oldtown MD Allegany 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21555 USA 17115 Maniford Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify. white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Papartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mentalonce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finish Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Thomas Barnhart Lorraine (Riggleman) Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21555 Oldtówn Lorraine Barnhart 17115 Maniford Road mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Scarpelli Funeral Home,P.A. 1 Burial 2 Xemation 3 Removal from State 5/19/201 MD 4 Donation 5 Other (Specify) Cresaptown Ignatur / Funeral Servic Licenses 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Onknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d, Date signed (Month, Day, Year) ٩ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 WILLOWPROOK MAVROMATIS M.I 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

		1	For State Registrar	Otato or marylana	Certi	ficate of D	eath		Reg. No.		
	Physicia Medic	n/	1. Decedent's Name (First, Middle, La	BOWDE				2. Date of De Month	Day 2	Year O	3. Time of Death
	Examin	_	4a. Facility Name (if not institution, given the Sapeake H	e street and number) ospice House	4	tb.City, Town, or I	Location of Death			ty of Death  Arun	del
	Funeral Director		5. Social Security Number 6.	Sex 2 Age (In yrs. last bit		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	v Year)	Countr	ace (State or Foreign y) ington, DC
	aryland a-f show fied at	, l	Usual Residence of Decedent	Georges Bow		tion				10	d. Inside City Limits
	with the Ma 23a or 28 ust be noti	Funeral Director	10e. Street and Number 12413 Shawmo	nt Lane		10f, Zip Code 20715			10g. Citizen o		ry?
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene, is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ፟፟ X Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	s Decedent of His res, specify Cubar	f Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.)  No Specify:			14. Race - American Indian, Black, White, etc.  Specify: Caucasian		
21215-0036	within 72 hours after death with the Maryland glene et than "natural" or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest to Elementary/Seconday (0-12)	grade completed)	(Give kir life. DO	nt's Usual Occupa nd of work done di NOT use retired) maker	ation uring most of worki	ing	16b. Kind of	Business Indi	ustry
land ?	should be filed who and Mental Hyg ris marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last John Donald	Holliday			18. Mother's Nam Mary M				
Baltimore, Maryland	427		19a. Informant's Name/Relationship Margaret H.	(Type, Print) Pascoe/Sister	9b. Mailing 139	Address (Street a	nd Number or Rura	Vien	na, VA	221	82
imore	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	☐ Removal from State Removal from State Fair	fery, crema	tion (Name of tory or other place Memoria k	h May	18, 11	Fairf	*	A
Balt	permit. F Departm Importal any inju		21. Signature of Funeral Service Lice	12 CC0423	Н	ome, 99		dock R	d., Fa	airfa:	x, VA22032
	Hiysician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do one course on each line.  a	0	the mode of dying	g, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onse d D⇒t
	Δ.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence	e of):						
0	ificate be executed ig physician an as the burial-tr (s)	cal Exa	that initiated events resulting in death) Last	C. Due to (or as a consequence	e of):						
Box 6	e death certificate the attending phy hed for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal deaded 4 Pregnant at time of death		Ectopic pregnanc Other (specify)	у			Date of delive	ory Day Year
s, P.O.	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but not resulting	g in the un	derlying cause giv	ren in Part I.				e cause of death?
Division of Vital Records, P.O.	≥ 85 S	Completed						24a. Was auto perl 1 \square Yes		b. Were autop prior to cor death? 1 \( \subseteq Yes	osy findings available mpletion of cause of 2   No
/ital	sician: certific lirector,	To Be	25. Was case referred to medical examiner?  1  Yes 2  10	Hospital: 1 ☐ Inpatient 2 ☐ ER/	(Outpatient	_ Othe	ace of Death (Checer: 4  Nursing H		idence 6 🖵	ther (Specify	MANDRIA
on of \	Attending Phys or death. ector: After this by the funeral di		27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day, Year)	o. Time of injury	.28c. Injun work	y at		how injury occ		HOUSE
Divisio	al or Attending s after death. Il Director: After ed in by the fune	Certificate:	3 Suicide 6 Could no 4 Homicide determin		, farm, stree	et, factory, office			(Street and Nur wn, State)	nber or Rural	Route Number,
_	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	(Check 2 Modical Exa only one) 3 Certifying N	hysician: To the best of my knowledg aminer: On the basis of examination and lurse Practioner: To the best of my knowledge.	d/or investi	gation, in my opinic eath occurred at th	on, death occurred a e time, date and pla	at the time, date	and place, and he cause(s) and	due to the cau manner as st	ated.
	To the within 2 To the Comple		29b. Signature and title of certifier	ylon N	P	29c. License	8703		29d. Date sig	ned (Month, I	Oay, year)
			GENEVIEUE !	completed cause of death (Item 23)	HOJYY	(T2 pp.)	EFEW:	E HW	, Ans	APOLI	S.M.D.2140
	Sta Registi		31. Date filed (Month, Day, Year) NAY 20 2	37. Registrar's Signature	pa	Marie I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ ROBERT STANLEY BRADLEY, JR. Month-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumber1and Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, **Funeral** 6. Sex Director 236-54-8981 06/10/1935 West Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner m ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director WV 1 Yes 2 X No Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 83 Buser Street 26753 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Kelly-Springfield Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Tire Production Worker Tire Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked any injury or other traumatic expressions. be Robert Stanley Bradley, Sr. Hilda Sheetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Bradley / Wife 83 Buser Street, Ridgeley, WV 26753 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Restlawn Meml.Gardens 05/10/2011 LaVale, MD 21. Signature of Funeral Servi × License 22. Name and Address of Facility Upchurch Funeral HOme, 202 Greene St., Cumberland, MD nehu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) CORONARI Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit ENAL Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L g Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed After this certificate 2 🗌 No 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) CARDIOVASC.

n & State

Registrar

31. Date filed (M

DHMH 17 Rev 7/2009

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12502 WILLOWSROOK, CUMBERLAND, MD 21502

and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18067 State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aleasha Ann Bishop 7:40 P М Mav 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16701 Harves Lane, SE Cumberland Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Min 1 - M 2 - F 215-48-2448 54 Director Marvland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16701 Harves 21502 USA Lane, SE death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or p Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: than "natural", Specify. 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other tha Clerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Peggy Davis Paul Mason Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16701 Harves Lane, SE, Cumberland, MD Gary L. Bishop / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place)
Cumberland Crematory 1 Burial 2 Cremation 3 Removal from State 05/12/2011 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as curdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Mers avernoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): and I-transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🖟 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician; The law autopsy performed? Yes 2 2 No has 1 Yes 2 No 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? 2. KNo Hospital: Other: 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1-P Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sunil K. Gupta, M.D.,

09

P.O.

29c. License number

625 Kent Avenue, Cumberland, MD

D33280

29d. Date signed (Month, Day, Year) May 9, 2011

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 2140 P M Berkenbaugh Francis DeSales 2011 Mav Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Hagerstown 78 E. Irvin Avenue 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 11/03/1919 Months Hours Country) Marvland 1 🕅 M 2 🗆 F 91 Director 212-12-8135 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Cumberland 1 Yes 2 No Allegany MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA Funeral 21502 116 Grand Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. 1 Never Married 2 X Married 1 Types 2 No 1943-If Yes, Give þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced White 1946 Year or Dates. 16h Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Optical Laborer 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Brehany Helen ပ J. Berkenbaugh John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 78 E. Irvin Avenue, Hagerstown, MD Ann Suter / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 05/16/2011 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service bicenses 10 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) executed cate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 5 Other (specify) 1 ∐ Yes 2 l g ☐ Unknowr q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available BLADDER CANCI 24a, Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Daughter's Specify) Residence examiner? Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 2 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier The little and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number May 16, 2011 D0054004 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221-E National Highway, LaVale, MD 21502 Shiv C. Khanna, M.D.,

DHMH 17 Rev 7/2009

**State** 

Registrar

31. Date filed (Month, Day, Year)

NAY 16 2011

Darke

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Lionel Francis Baker Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Western Maryland Regional Medical Center Cumberland Allegany 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Country) Maryland **Funeral** Days 1 M 2 □ F Hours Min 218-38-0360 March 16, 1940 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a, State Director 1 X Yes 2 No Midland Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ō must be r Funeral 15011 Paradise Street 21542 **USA** death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Examiner Armed Forces?,

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ "natural", or Maryland 21215-0036 hours after 1 Yes 2 No Specify If Yes. Give White 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) High School Teacher 12 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lionel Baker Catherine O'Brien permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eileen Baker - Wife 15011 Paradise Street, Midland, Maryland, 21542 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Josephs Catholic Cemetery Date May 13. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Midland, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Brand 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 Z No 1 Yes Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No ျှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury 28c. Injury at Certificate: (Month, Day, Year) 1 Natural 5 Pending work? 1 Yes 2 No М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d Date signed (Month, Dav. Year) M.D. 3 death (Item 23a) (Type, Print) 30. Name and address of person who 12500 W. Hawkersk Road Cumberland, Mary land Date filed (Month, Day, Year) 82. Registrar's Signature State MAY 12 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Baird Month Alan Paul 2้ชี้ 11 1500 P May 11. Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Allegany Health Nursing & Rehab Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 - F Hours Min. 043-36-9485 66 <u>California</u> Director 7/25/1944 Usual Residence of Decedent show 10a. State 10b. County with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Cumberland 28a-f MD Allegany 1 X Yes 2 No 10f. Zip Code 2**1**502 10e, Street and Number 9 10g. Citizen of What Country? Funeral 630 Hilltop Drive items 23a within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates o þ 1 X Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: than "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event the May injury or other trauma College (1-4 or 5+) 12 Vice President Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruehl 2 Baird Helen Mav Thomas Alger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 W. Whisconier Road, Brookfield, CT Larry Baird / Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Cumberland Crematory 05/12/2011 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Sgn ture of Funeral Service 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. disease or condition resulting in death) BRE Medical Due to (or as a consequence of): Examiner HTT Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events Dementia and resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1  $\square$  Yes 2  $\cancel{X}$  No 3  $\square$  Probably 4  $\square$  Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 X No page 2 upleted filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation within 24 hours after deat To the Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29d. Date signed (Month, Day, Year)
May 11, 2011 29c. License numbe

Registrar

State

31. Date filed (Month, Day, Year) **MAY 12 2011** 

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me and address of person who completed cause of death (Item 23a) (Type, Brint)
Denise Wilson, CRNP, 730 Furnace Street, Cumberland, MD

32. Registrar's Signature

R137604

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 5 Physician/ 0604 16 Brown, Revel <u>Artimus</u> Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner COMICC Gional Merical Ce 8. Date of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Country)
Kentucky Days 1 X M 2 □ F Months Hours ,1942 Director 68 311-44-0929 Usual Residence of Decedent items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2X No Willards MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21874 USA 36314 Poplar Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Ever in U.S.

Armed Forces?
1 ⊠ Yes 2 □ No 1961—
If Yes, Give
Year or Dates. 1978 Black, White, etc. 1 Never Married 2 X Married ð "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Mechanic Automotive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Lillie Hansford Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 285 Pittsville, MD 21850 Jennie Darlene Brown- Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pittsville Cemetery 5/21/2011 Pittsville, Maryland 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Bounds Funeral Home Salisbury, MD 21804 705 E Main St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List driy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to minimize cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗌 No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural injury 5 Pendina 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Me Inal Experience: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, certifying home pranticular. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on To the within 2 29d. Date signed (Month, Day, Year) certifier 29b. Signature 450497 WD 21801 who completed cause of death (Item 23a) (Type, Print) WA ne and addres (S) E Carroll der ncis State Registrar

11-03957		Please Type or Print in Black Indelible Ink. Ensure All Copies		ole.	
James Edward Ca		, Jr. State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death		2011	18052
Physicia	F	Registrar	Reg. I 2. Date of Death		3. Time of Death
Medical Examin		James Edward Cain Jr.	Month Da May 27, 201		1139 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
		Leonards Mill Pond Salisbury	In not sense	Wicomico	polace (Ctate or
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(N	Foreign	nplace (State or
Director	4	592-32-9766 1 1 MM 2 F 42 Yrs. Yrs.	Iteh. 3,	1969	intry)Maryland
k g		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County           10c. City, Town or Location			10d. Inside City Limits
p qq		MD Wicomico Fruitland			1 Yes 2 No
arylar at on	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Coun	try?
th the Maryland 23a or 28a-f she	5	519 White Pine Dr. 21826		USA	
be no	盲	11 Maritol Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Spe		14. Race - Americ White, etc.	can Indian, Black,
death or ite	Funeral	1 Never Married 2 Married 1 Yes 2 No No	,,	21	/-
s after real",		3 Wildowed 4 V Divorced of Yes, Give Yaar 1998 1 Yes 2 V No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo	ork done 16	Specify: / /	adustry .
hour "natu	<b>B</b>	Elementary/Secondary (0-12) College (1-4 or 5+)			
hin 75 hin 75 he then		2 Surgical Techni	cian	HOSPin	tal
5-0036 lied within 72 hours a Hygiene. t other than "natura the Medical Examination of the Medical Exa	Completed by	17. Father's Name (First, Middle, Last)  18.Mother's Name (	First, Middle, Maid	den Surname)	
2121. wild be fill Mental F marked c event, i	å	James Edward Cain, Sr. Paule-	He J	ones	
이 음 말 후 할	卢	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	4 1	0.0	1
ore, MIss 1 and 2 so of Health a If item 27 is the in a mer traum		20a, Method of Disposition  20b. Place of Disposition (Name of cemetery,	heste Date 2	r, /Vary/ D Location - City or	
MOFe, Pages 1 a nent of He ant: If ite	- 1	1 Burial 2 Cremation 3 Removal from State crematory or other place)	5/11	1 la actain	Marilland
- 8291	d	4 Donation 5 Other Specify: IC N P STCY CT/VIETETY /	7 01	VIES (CT)	Mar land
Balti permit. Departu Import	Ц	21. Signature of Funeral Service Licensee  22. Name and Address of Ficility  Henry Funeral H  5 10 Washing tous  23a Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or	ome, K. A.	ridge MI	2 21613
Physician	1	20d. 1 dit I. Einter the diocase, or complications and course and	respiratory arrest,	shock or leart	Approximate Interval Between Onset and
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. <b>Drowning</b>			Death
£ Zxammer	-	or condition resulting in death)  Due to (or as a consequence of):			
	<u>.</u>	Sequentially list conditions, if any, leading to immediate			
	Examiner	cause. Enter Underlying Cause  (Disease or injury that initiated			
ed nsit	Exa	events resulting in death) Last  Due to (or as a consequence of):			
ecut and	<u>a</u>	x UNPENDED ☐ AMENDED 23a,27,28a-f,per me,g916 6-8-1	1 sm		
ox 68760, sub certificate be ex attending physician for use as the burial for use as the	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Box 68760, a death certificate be the attending physic of for use as the burned for use	an/	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnan	псу	Month D	ay Year
OX (eath ce ath ce attence for use	sici	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
C. B. the de by the ched fi	된	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
P.O. es that the igned by be detach	호		1 Yes	2 No 3 Prob	ably 4 Unknown
rds, requir	ete		24a. Was an autopsy		topsy findings available completion of cause of
e law te has	Completed		performe	ed? death?	
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	ပ္ပို	25. Was case referred to medical 26.Place of Death (Check o		<del>-</del>   <u> </u>	
of Vital Records, ag Physician: The law requin ther this certificate has been si neral director, page 2 should be	8	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 1 Nursing	Home 5 Re	sidence 6 🗸 Other	Scene
n of Vi ding Physi  After this funeral dir	on: T	(Month, Day, Year)	28d. Describe how	v injury occurred	
tendi death.	atio	Accident   Sending   fd 5-27-11   fd 11:39am   Tes 2   Tes 2   Tes 2   Tes 2   Tes 2   Tes 2   Tes 3   Tes 3	Subject_		
Division  Division  spital or Attendii  hours after death.  neral Director: /	Certificati	3 Suicide 6 Could not be determined (Specify) Found in pond	or Town, Stat	e) <b>Leonards</b> y <b>, Md</b> .	ral Route Number, City Mill Pond
ospita hours y fille		4 Homicide determined (Specify) Found in pond  29a. Certifier  Check only  Check only  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	the time, date an	d place, and due to th	e cause(s)
To with	¥ S	and manner stated.  29b. Signature and title of certifier  29c. License number	2	9d. Date signed (Mo.	nth, Day, Year)
		O.C.M.E.	1	Vlay 28, 2011	:
	ŀ	30. Name and address of person who completed cause of death (Item 23a)			
		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 212	223		
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. Norma Leola Commotes 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Cumberland Allegany 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 1 🗆 M 2 😾 F Days Min 0671074914 194-03-0224 96 Director Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Allegany Cumberland 1 Xyes 2 No 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? Funeral 146 Polk Street 23a 21502 USA items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White etc. ō 1 Never Married 2 Married 72 hours after þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 Is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Seamstress Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Ebaugh Edna Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger E. Commotes / Son P.O. Box 1111, Cumberland, MD 21501-1111 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1  $\square$  Burial 2  $\cancel{X}$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) Cumberland Crematory 05/17/2011 Cumberland, MD 21. Signa ure of Funeral Service Vice 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1 Poter the disease Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transit and attending physician Physician/Medical that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Day Month Year Pregnant at time of death signed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an The law page 2 s has autopsy death? performe certificate 1 Yes 2 No Yes **Division of Vital** Hospital or Attending Physician; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Tyes 2 No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending s after death. 1 Yes 2 No Investigation 6 Could not be the Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis or examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar on who completed cause of death (Item 23a) (Type, Print)

D0066101

12500 Willow brook

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month roaker May 2011 8:30 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot The Pines Genesis HealthCare Easton 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2 - F Months Days Hours Min. (Month, Day, Year Director 10-Maryland Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☑ Yes 2 ☐ No Sony: 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral Sawmi 216 215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 55:54. rivate rsing Be Croaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Stowers lark Mable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mable ane-Graso pville 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Doris Date 1 2 Burial 2 Cremation 3 Removal from State 28/11 4 Donation 5 Other (Specify) Cemetery srasonville, MD Name and Address of Pacility lenry Funeral Home, P.A. Sio Washington St. Cambridg Signature of Funeral Service Licensee MD.21613 23a. Part 1. Enter the disease, or complications that cause ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** rears Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury U ans ig physician and as the burial-transi that initiated events resulting in death) Last Physician/Medical the Hospital or Attending Physician. The law requires that the death certificate be thin 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: for use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie ٥ 5.16.11 Name and address of person who completed cause of death em 23a) (Type, Print) -ASTON MD 21601 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 12:29 A M **Physician** Lunning 2011 nam JOSeph Walton 4a. Facility Name (If not institution, give street and number) /Medical 4b. City Jown, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 8/12/1944 WEST VIRGINIA 220-42-2191 **Director** 66 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director MD FREDERICK BRUNSWICK 10g. Citizen of What Country? 10f. Zin-Code 10e. Street and Number USA 215 TAMARACK WAY 2<u>1716</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status traumatic event, the Medical Examiner 1 Yes 2 V No
If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. þ WHITE 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) US GOVERNMENT Elementary/Secondary (0-12) DESIGN ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WANDA LEE DYER JOSEPH WALTON CUNNINGHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important; If item 27 is any Injury or other trau 215 TAMARACK WAY, BRUNSWICK, BRENDA CUNNINGHAM/SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MAY 28. REST HAVEN CFM FTFRY FREDERICK MD 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, PO BOX 821, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. MARTINSBURG, Interval Between Onset and Death Immediate Cause (Final a. Due to (or as a consequence of) **Physician** disease or condition resulting in death) /Medical Examiner nemorrhagic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consuluence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician d for use as the buri Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 TEctopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 E-No Yes 26. Place of Death (Check only one) or Attending Physician; after death. 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 🗆 DCA ပ္ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 ☑ Natural Certification: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 3 Suicide City or Town, State) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Hospital 29a. Certifier Medical (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES - 000 25 , 2011 10 SW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 FARMADI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 7 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Day 10:45A M Mar 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death GLEN BURNIE whe arunde 7. Age (In yrs. last birthday) **8.** Yrs. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min SCOTLAND 1 □ M 2 🖼 F Director ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 Mo ANNE ARUNDE LTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced MITE th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1860 CEDAR RO. PAGADENA, MD. Z11ZZ CLARK, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) -28-11 4 ☐ Donation 5 ☐ Other (Specify) ODENTON, FUNERAL HOME AURHERTY 23a. Part 1. Enter the greatse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Physician/ -emen disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the burial-transit Memid and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical ate has been signed by the attending p page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒No 24a. Was an autopsy this certificate 2 **N** N completed filled in by the funeral director, 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 \( \subseteq \text{Yes} \) Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 No Investigation Accident within 24 hours after deat To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) rina CID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's S 31. Date filed (Month, Day, Year) State 07 2011 Registrar

DHMH 17 Rev 7/2009

Baltimore,

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	e of Ma	ıryland		rtment of F		and Me	ental Hy	giene		
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	Physicia		Michael Wayne							1		12 <sup>7</sup> 201	Year	1415 M
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	L Xuiiiii	Ϋ.	Anne Arundel M	edical (	Center	:		Ann	apoli	s		Anne	Arun	del
T	Funeral		5. Social Security Number	6. Sex ▼XX M 2 □	7. Age	(In yrs. last		If Under 1 Year Months Days			B. Date of Birt	h /, Ye <u>a</u> r)	g. Birth	place (State or Foreign
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	and show	٥	10a. State 10b. County			10c. City, T	own or Loc	ation						10d. Inside City Limits
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	th with	Funeral	1390 Primrose				140.11		1403	1-0 (01	f . V = = 1 N =		SA	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☑ Mar</li><li>3 ☐ Widowed 4 ☐ Divorced</li></ul>	ried 和M	Decedent Ev d Forces? Yes 2		nam <sup>lf</sup>	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2002 No	ın, Mexican	, Puerto Ri	can, etc.)		ace - Americ ack, White, fy:	
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ore,	of He of He r oth		20a. Method of Disposition  1 Charles 2 Cremation	3 Removal	from State	20b. Plac	e of Dispo	sition (Name of natory or other place	e)	Da	te	20c. Location	n - City or To	own, State
ij	Page ment tant: jury o		4 Donation 5 Other			Hill		t Memoria			5/2011		polis	
Baltimore,	permit Depart Impor any in		21. Signature of Funeral Service	censee				Name and Addres  Kidgely				Funeral s, MD 2		, P.A.
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P.0	that i	by P	Part II. Other significant conditi	ons contributing 24'c Me			ing in the u	nderlying cause giv	ven in Part	l.				he cause of death?
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ouc	inding ath. r: Afte ne fun	icat		igation	Month, Day,	( Year)	injury	M 1 □	<br Yes 2□	No				
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	inod   28e. F	Place of Injur ouilding, etc.		e, farm, stre	eet, factory, office		28	3f. Location (S City or Tox		ber or Rura	l Route Number,
Ö	pital o		on out a Vonden	Physician To 1	the best of o	my knowlad	an doath s	accurad at the time	data and	place and	due to the co	uso(s) and mar	anor as state	
	Hos 24 hc Fune leted 1	Medical	(Check 2 Medical	Examiner: On the	e basis of ex	amination a	nd/or invest	occured at the time tigation, in my opinion death occurred at the	on, death or	curred at the	ne time, date a	and place, and o	due to the ca	ause(s) and manner stated.
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	10×1		30. Name and address of person	who completed	cause of de	eath (Item 23 Medical	3a) (Type F	rint) way ar	nua pot	là r	lo			
Ì	Stat Registra	te ar	30. Name and address of person Sire of Ber 31. Date filed (Month, Day, Year)	2011	32. Registrar	r's Signatur	1. 10	uls						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year ANTHONY ROBERT DEJESUS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF 15. Social Security Number 16. Sex MONTGOMERY RFTHFSDA
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

NV (In vrs. last birthday) 8. Date of Birth Funeral Days 4-14-1975 Months Hours Min. 1 🛛 M 2 🗆 F 36 NY Director 127-58-8525 Usual Residence of Decedent 28a-f shov the Medical Examiner must be notified at 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Rockland NY 1 X Yes 2 No Spring Valley 5 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? 23a 26 Locust Street 10977 US 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 permit. Page 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examin ange. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Mortgage Banker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert DeJesus Virginia Cortes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Villafane/Mother 26 Locust Street, Spring Valley, NY 10977 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 X Removal from State Brick Church Cemetery 5/25/2011 Spring Valley, NY 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A ature of Funeral Service 5538 Marlboro Pike, Forestville, MD 20747 23a. Par 1. Inter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition nset and Death Physician/ months Medical resulting in death) Examiner Hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Physician/Medical Box 68760 attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multicentric Castleman Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an Jas autopsy berform rmed? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 10 CENTER DRIVE BETHESDA, MD 20892 Khozin 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Month Physician/ Edward Dove, Jr. 011 10:00AM Paul May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Oakland Garrett Co. Memorial Hospital If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 1 X M 2 - F 778, 74, 944 Maryland 232-70-0759 66 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Oakland MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21550 735 Snowy Creek Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ıral", or iten I Examiner n Armed Forces? þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Trucking Company it. Page 1 and 2 should be filed withintrent of Health and Mental Hygien.

rrant: If item 27 is marked other the njury or other traumatic event, the Owner 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lewis Ethel Ruby Dove Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 735 Snowy Creek Rd., Oakland, MD 21550 Sharon E. Dove/ Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Pleasantovatiles XBurial 2 ☐ Cremation 3 ☐ Removal from State Oakland, Maryland 5/21/11 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Newman Funeral Homes 21. Signature of Funeral Service Licenses 21550 Second St., Oakland, MD 203 S. Walter 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f Yes 2 No g Unknown P.O. ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed certificate has been si rector, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No : After this certification : 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No Natural 5 Pending within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu death. ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certified D23979 idress of person who completed cause of death (Item 23a) (Type, Print) Fourth St., Oakland, Robert 311 N. Goralski

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month George Durr Jr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Western MD Regional Medical Center 8. Date of Birth (Month, Day, Year) **May 12**, 1927 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Months Country)
Maryland Director 84 216-22-6787 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Frostburg Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Honeysuckle Lane Funeral 21532-U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Kyes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Automobile Repairs** Auto Mechanic 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 George Durr, Sr. Viola Housel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-100 Honeysuckle Lane Maryland Mildred Durr wife Frostburg Page 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗹 Burial 2 🗌 Cremation 3 🗎 Removal from State Maryland Frostburg Frostburg Memorial Park May 26, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy 23b, Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Month Pregnant at time of death the page 2 should be detached 9 Unknown been signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CFREBROUMC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy After this certificate has performed? 1 Yes 2 No Yes 2 N funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Dea 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: a Hospwan ∩ 24 hours after death. he Funeral Director: Aft Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier

State Registrar CumberLANd

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Medical 0850 2011 Rose M. Day 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner mberlanc Regional Medical Hileaan If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6. Sex 8. Date of Birth 1 M 2 W F Director Maryland 219-44-0379 66 July 07, 1944 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Allegany LaVale 1 Tes 2 No 0 10e. Street and Number 10f. Zip Code 12110 Cash Valley Road NW 10g. Citizen of What Country? "natural", or items 23a Funeral 21501-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. White Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " Seamstress retired) O College (1-4 or 5+) Elementary/Seconday (0-12) Clothing manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Whitefield **Evelyn Denniser** 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12110 Cash Valley Road NW LaVale Maryland 21501-Wilmer G. Day Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Date 1 K Burial 2 Cremation 3 Removal from State Prostburg Memorial Park May 28, 2011 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura upréral Service Licence Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Vin letus 1 Yes 2 No 3 Probably Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law After this certificate has funeral director, page 2 s autopsy death? 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 26 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 至 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred - Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation ☐ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1/Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 🖆 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikc Ad W trar's Signature State 26

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 MARY 540 PM Dellatorre 2011 Medical 8 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 11104 Luxmanor Road Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov. 29, 1921 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. 1 M 2 X F Days Hours 89 Yrs. D.C. Director 578-18-0770 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville 1 Tes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıra!", or items 23a oı Examiner must be Funeral 20852 11104 Luxmanor Road USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Je filed within ential Hygiene arked other than "natural", o Baltimore, Maryland 21215-0036 White 1 Yes 21 No Specify: Specify. Completed 3 √ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be permit. Page 1 and 2 should be filet Department of Health and Mental H-Important: If item 27 is marked oft any injury or other trainers. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Luigi Carpineti Julia Moretti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11104 Luxmanor Road, Rockville, MD 20852 Carolyn Julia Allaire/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State May 24 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Juneral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph. sician/ Parkinson's disease or condition resulting in death) yours Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year 2 No 9 Unknown 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 > Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2 **S**N 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🔽 No 1 Yeş မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🕰 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A: death. Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of avaningtion and/aximumitation is a stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar Dr.

Piccard

ddress of person who completed cause of death (Item 23a) (Type, Print)

Coleman

31. Date filed (Month, Day, Year)

1355

37142

Rockille MD

5-19-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2011 9:30 A May Alice Lois Ellis Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 500 N. Harry S. Truman Drive # 402 Largo If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 📑 Months Days Hours 06/27/1926 spartenburg, S.C. 84 Director 251-28-9885 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 😾 Yes 2 🗌 No Md. Prince George's Largo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20774 U.S.A. 500 N. Harry S. Truman Dr., # 402 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 ☒No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 8th College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert B. Brewton, Sr. Fannie Mae Hill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 6925 Kent Town Drive, Landover, Maryland 20785 Wanda J. Gorham/Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🕅 Burial 2 🗌 Cremation 3 🗎 Removal from State George Wash. Mem. Cem, 05/24/11 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Henry S. Washington & Sons Co., Inc. . Signature of Funeral Service Licenses naLI ar C\_20019 4925 Burroughs Ave. N.E. Washington, D. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ a Chronic Obstructive Airway Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death n signed by the a 9 Unknown g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Hospital or Attending Physician: The 1 Yes 2 No 1 Yes 2 No After this certifications and director, 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 May 24,2011 veltz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, M.D. 7525 Greenway Center Drive, Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

NAY 2 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiene

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ı	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th Day	Year	3. Time of Death	
	Medic Examin	al .	4a. Facility Name (if not institution, give stre		DMC	4b. City, Town, or	Location of Death	03	4c. County		12	
1	i		5. Social Security Number 6. Sex	STIZEET  7. Age (In yrs. Is	ant hirthday)	Frien If Under 1 Year	If Under 24 Hrs.	8, Date of Birt	Gen		lace (State or Foreign	
	Funeral Director		190-28-8413	1. Age (iii yis. iii 7.5	Yrs.	Months Days	Hours Min.	(Month, Day 05/25/1	, Year) 935	Count		
	and show	or	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits	
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	with the 23a or ist be r	eral	10e. Street and Number 239 Maple St.			10f. Zip Code 215	31		U.S.		try ?	
36	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at its.	by F		. Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		Nas Decedent of His f Yes, specify Cubar I ☐ Yes 2 🔀 No		ecify Yes or No- Rican, etc.)		e - Americ ck, White, e Whi	etc.	
9-5	hours natura dical E	oletec	15. Decedent's Educi	Year or Dates.	16a. Dece	dent's Usual Occupa kind of work done di	ition	ina	16b. Kind of Bi	usiness Ind	dustry	
121	ithin 72 ene. • <b>than</b> " the Med	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	o NOT use retired) nunicati	· ·	rig	U.S.	Air	Force	
nd 2	be filed within ental Hygiene. <b>ked other tha</b> ic event, the N	ادها	17. Father's Name (First, Middle, Last)	13-4-bon			18. Mother's Nam	e (First, Middle, Mae	Maiden Surname Davi	 d	·	
ıryla	I and 2 should be file F Health and Mental F item 27 is marked o other traumatic eve		Carl Elmer F  19a. Informant's Name/Relationship (Type,	Idmiston Print)	19b. Mailii	ng Address (Street a					Code)	
, No	nd 2 sh ealth ar m 27 is ner trau		Carol J. Edmisto	on/ Wife	239	Maple S	t., Fri	endsvi	lle, M	D 21	531	
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or oth		20a. Method of Disposition 1	moval from State	cemetery, cree Lon Ce	osition (Name of matory or other place emetery	5/2	0 / 1 1	Accid	ent,	MD	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Lidensee	attend 1	22	2. Name and Addres	s of Facility Ne nd Ave.	wman F , Frie	uneral ndsvil	Hom	nes P.A. ID 21531	
'n			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the deat		er the mode of dying	, such as cardiac				Approximate Interval Between Onset and Death	
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	uence of):	<i>lance</i>				-	reard	
	Examiner	Ļ	Sequentially list conditions, b.							_		
	ted       nsit	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Duc to for as a son seq	Uerite Utj:							
	icate be executed physician and s the burial-transit	edical Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
200	icate be physic s the bu		d.									
Box 68	Physician: The law requires that the death certifica this certificate has been signed by the attending prail director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	2. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	Ectopic pregnanc Other (specify)	у			ate of deliventh	ery Day Year	
P.O.	es that the signed by t be detach	ò	Part II. Other significant conditions control	ibuting to death but not re-	sulting in the	underlying cause giv	en in Part I.				ne cause of death?	
cords	requi been should	Completed						24a. Was	an 24b.	Were auto	psy findings available impletion of cause of	
- Re	n: The la ficate ha		25. Was case referred to medical			os Die	ace of Death (Chec	1 Yes	2 No	death? 1  Yes	2 No	
Vita	nysiciai iis certii directo	To Be	ovaminar?	spital: 1		nt 3 🗆 DOA Othe	ar.	,	dence 6 🗌 Oth	ner (Specif)	()	
n of	Attending Physician: The law ir death. sctor; After this certificate has by the funeral director, page 2		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time o injury	work		28d. Describe l	now injury occur	red		
Division of Vital Records,	or Atten after deat Director; in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif				28f. Location (S	Street and Numb vn, State)	er or Rura	l Route Number,	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director, After completed filled in by the funer	Medical	(Check 2 Medical Examine)	an: To the best of my knov r: On the basis of examinatio Practioner: To the best of m	on and/or inves	stigation, in my opinic	n, death occurred a	at the time, date a	and place, and du	ue to the ca	iuse(s) and manner stated	
	To the within To the comple	Σ	only one) 3 L Certifying Nurse I  29b. Signature and title of certifier	ractioner, to the best of the	, mowede,	29c. License		,	29d. Date signe		Day, Year	
	•	6	30. Name and address of person who con	npleted cause of death (Iter	m 23a) (Type.	Print)	6150	1	5/	19	[ [ ] ]	
	<b></b>	VΑ	Paul Daniel	Miller Do	691	wolff	teres I	160	iklan	5	MD	
i de la companya de l	Sta Registr		31. Date filed (Month, Day, Year)	32, Registrar's Signa	ature de	Kel				2	133-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May 14, 201 Year 8:04 M David Morgan Evans, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 2 Alexander Street Allegany Lonaconing 5. Social Security Number Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) April 20, 1919 Country) Maryland 213-14-8435 92 Yrs Director Usual Residence of Decedent works 10d. Inside City Limits 10a. State 10b. County at 10c. City. Town or Location Director of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sl other traumatic event, the Medical Examiner must be notified a 1 Yes 2 No Allegany Lonaconing Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2 Alexander Street 21539 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 ☐ Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Army Core of Engineers Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Evans Mary Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Morgan Evans, Jr. 110 Forest Drive, Cumberland, Maryland, 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date May 17, Department of H Important; If ite any injury or ot cemetery, crematory or other place)
Laurel Hill Cemetery 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moscow Mills, Maryland 2011 Signature of Funeral Service License 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 IF FEMALE s, outcome of pregnancy
Live Birth 2 Tetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Month Pregnant at time of death 1 | Yes 2 | 9 | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: ပ 1 Tes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0017565 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bullino N2t 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Amend Item 2 per arring 160	atificate of Death	nd Mental Hyલ્ ા	giene 011	18066
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			ath <b>05/11/2011</b> Day Year	
	Medic	al	Lois Allison Eisinger		May 11,	2001	6:05 A <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)  Victory Terrace	4b. City, Town, or Location of Potomac	Death	4c. County of Death Montgomer	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 2			hplace (State or Foreign
	Director		093-16-9614 1 □ M 2 🔼 88 Yrs.	Months Days Hours	Min. 10\mathred{M}21\mathred{M}	Wash	nington, DC
	ind ihow at	or	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation			10d. Inside City Limits
	//anyla 8a-f s tified	rect	MD Montgomery Potoma	c			1 🏿 Yes 2 🗆 No
	be filed within 72 hours after death with the Maryland antial Hygiene. Med other than "natural", or items 23a or 28a-f show ted other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 11646 Partridge Run Lane	10f. Zip Code 2085	4	10g. Citizen of What Co United Stat	
ဖွ	fter death , or item: aminer m	by	Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No	Nas Decedent of Hispanic Origin f Yes, specify Cuban, Mexican,  □ Yes 2 🏋 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	e, etc.
8	ours a tural" al Exa	Completed	3 XWidowed 4 Divorced Year or Dates.			Specify: Wh	
5	72 ho in "na Medic	mple	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most o O NOT use retired)	of working	16b. Kind of Business I	Industry
212	within giene. ner tha t, the I		Elementary/Seconday (U-12) College (1-4 or 5+)	emaker		Own Home	
and	I be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Warren Samuel Allison		's Name <i>(First, Middle,</i> garet Olive		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be file Department of Health and Mental Important. If item 27 is marked c any injury or other traumatic eve once.		la 1 . 2 = 1 / C	ng Address (Street and Number 6 Partridge Ru			
nore,	age 1 and ent of Hea t; If item / or othe		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition cemetery, cref	sition (Name of natory or other place)	Date	20c. Location - City or	Town, State
Ħ	mit. Pa bartme bortan 'injuny		4 ☐ Donation 5 ☐ Other (Specify) National  21. Signature of Funeral Service Licensee 22	Crematory 0  2. Name and Address of Facility		Falls Chur	
m	lmp Den		3chla Ranz	130 Wisconsin	Ave. NW Wa	shington, D	C 20016
4	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a. Failure to Thrive to Thrive to Thrive to the cause of the caus	er the mode of dying, such as ca			Approximate Interval Between Onset and Death Year
	Medical Examiner		resulting in death)  Due to (or as a consequence of):				Years
	der red	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Parkinson's Dise			Years	
09	ath certificate be executed attending physician and for use as the burial-transit	dical Ex	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
9/89	certificate inding physuse as the	Med	IF FEMALE:				
Box 6	iaw requires that the death cer nas been signed by the attendi ? 2 should be detached for use	Physician/Me	23b. Was decedent pregnant in the past 13 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Live	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
P.O.	requires that the der been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
S,	uires t n sign ild be	ed by	Hypertension		1 🗆 '	Yes 2 ☐ No 3 ☐ Pr	robably 4 🔀 Unknown
ecord	The law requate has been page 2 shou	Completed			24a. Was autor	an 24b. Were autorsy prior to or death?	topsy findings available completion of cause of
ř	in: The ifficate or, pag		25. Was case referred to medical	26. Place of Death	1 🗆 Yes		Senior
Ĭ Ĭ	ysicla is cer direct	To Be	examiner? 1  Yes 2 No  Hospital: 1  Inpatient 2 ER/Outpatie	Other:		lence 6 🗓 Other (Speci	- 50101
Division of Vital Records;	ath. r: fter the funeral	Certificate:	27. Manner of Death  1 ★ Natural 5 ☐ Pending (Month, Day, Year)  28a. Date of injury (Month, Day, Year)  28b. Time of injury injury		28d. Describe h	ow injury occurred	
DIVISI	al cr Attends all cr Attends all Director:	l Certii	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (S City or Tow	Street and Number or Rui vn, State)	ral Route Number,
_	To the Hospital or Attending Physician: The within 24 hours aller death.  To the Funeral Director: "fler this certificate h completed filled in by the funeral director, page.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occ	curred at the time, date a	ind place, and due to the o	cause(s) and manner stated.
	ological three controls of the control of the contro		29b. Signature and title of certifier	29c. License number D31319		29d. Date signed (Month May 12, 20	n, Day, Year) 11
			30. Name and address of person who completed cause of death (Item 23a) (Type, Loreto S. Albiol MD 8218 Wisconsin A		sda, MD 20	 814	
	Stat	te					
	Registra	ar	31. Date filed (Month, Day, Year)  ANY 19 2011  32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 15,<sup>Day</sup>011 Frankovic Physician/ Theresa 4:10a M May Medical 4b. City, Town, or Location of Death 4c. County of Death
Montgomery 4a. Facility Name (if not institution, give street and number) **Examiner** Silver Spring 2541 Glen Allen Avenue #204 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 27 28 / 1922 New Hampshire 1 □ M 2 🛣 F 002-18-1174 **Director** 88 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 2541 Glen Allen Avenue #204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11 Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married ģ Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Maurice Pollard Mary Higgins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,20906$ 19a. Informant's Name/Relationship (Type, Print) 2541 Glen Allen Avenue #204 Silver Spring, Md Joseph Frankovic/Son timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Chesapeake Crem. 5/17/2011 Beltsville, Md. 4 Donation 5 Other (Specify) PHITE TO PACE OF REMIALDI FUNERAL SERVICE, P.A. of Funeral Service Lice Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph<sub>sician/</sub> Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** <u>Alzheimer's</u> Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate the attending physician and the for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Failure to thrive Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown detached cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔀 Yes 2 🗌 No 3 🗌 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 X No 1 Yes 2 No After this certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Algorithms of the funeral Director of the funeral pitches of the function o Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 16,2011 147528

State Registrar 10301 Georgia Avenue #304 Silver Spring, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lila Bahadori

MAY 20 2011

31. Date filed (Month, Day, Year,

M.D.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Mary Maxine Fritz 2011 7. 12:35 AM May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Cumberland Golden Living Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛱 F Months 08/30/1927 215-26-6835 83 Vre Pennsylvania Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at. within 72 hours after death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Director MD Cumberland Allegany 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1510 Frederick Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Tire and Rubber Laborer Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bridges Mav Robinette Charles Alfonso Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eldrin J. Fritz / Husband 1510 Frederick Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 05/09/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) Adams Family Funeral Home, f Funeral Servica Lic 22. Name and Address of Facility 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ elas disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to in realisticause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a nonsectionne of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2, 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.

neral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation

Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 🛛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion with the cause of the cause o (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 9, 2011 D33280

State Registrar

3

268

625 Kent Avenue, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrat's Signature

Sunil K. Gupta, M.D.,

10th P

Please Type of Printing Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Emmett Physician/ 21, Day 201 Year Menth 5:15 А м Fay George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Ft. Washington Hospital Ft. Washington If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth Hours 1 ∰ M 2 □ F Months Rivolle Island 059-10-0220 027/221 1917 94 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2XXNo Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Blvd. 20745 5426 Woodland Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 XXYes 2 \( \text{No} \) 1941 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: White Completed 3 X Widowed 4 Divorced 1969 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military Captain - Air Force 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of and 2 should be filed of Health and Mental H fitem 27 is marked ot rother traumatic even ည Mary McArdle Fay Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5426 Woodland Blvd., Oxon Hill, Maryland Joan R. Fay / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 7/1/2011 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State <u>+</u> 5 Arlington Nat. Cem. Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland Kules 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final cerebral vasular Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy rate has been signed by the atter page 2 should be detached for a in the past 12 months?
1 Yes 2 No Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 No To Be Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1731 (Type, Print)
1731 Livingshi Road Fat WASHINGTON, MID T. Tonna Willom 31. Date filed (Month, Day, Year) State MAY 2 5 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Mai Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 10 venue Winton 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Country)
Mary Jand (Month, Day, Days Months Min. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show
raumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 1 Yes 2 No Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 60 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black White etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give Black Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1echanic Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly Ave. TON Maruland 21601 nton 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mid Share Crematical Cemeter 20c. Location - City of Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 22. Name and Address of Facility
Henry Funeral Homes P. Ar
Signature The Signature Stock S Cambridge, MD.21613 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MD.2161 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final all carceerus quenures Physician/ disease or condition Medical resulting in death) Du to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Date to for as a positivities of the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buna Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has I page 2 s autopsy perform 1 🗌 Yes 2 🗆 No this certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) director, Be Residence 6 Other (Specify) 1 Tes 4 Nursing Home ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyler of Death 28a. Date of injury (Month, Day, Year) 28b. Time of funeral Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera injury work? Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗍 only one) 29d. Date signed (Month) wre and title of certif 29b. Signa 39887 18 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Smith, M.D. 8221 Teal Drive, Easton, MD 21601 egistrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eric, Grates 13:39 PM Medical Ma 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. Date of Birth (Minth Way, Ye 9. Birthplace (State or Foreign 1 M 2 - F 70-4110 Months Days Hours Min. Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married ☐ Yes 2 No 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify. 3 Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be ( 17. Eather's Name (First, Middle, Last) ဂ္ 9a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Nun er or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Significant Juneral Service Licente Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Vavicea Medical resulting in death) Due to (or as a consequence of): Examiner 6 months Sequentially list conditions, if any leach of the immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events 15 YEars Due to (or as a consequence of): attending physician and for use as the burial-trar resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for i 1 Yes 2 No in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alcaholism 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate the second of the second performed' 2 🗌 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury Accident Investigation 1 Tes 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1780909242 May, 17, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South arcene Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2011 9:15 A<sub>M</sub> Maÿ 23, Physician/ Graham Mary Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Clinton Southern Maryland Hospital Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs Social Security Number Age (In vrs. last birthday) **Funeral** Wew York Hours 0270471925 1 □ M 2x x F 86 114-14-1096 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2X XNo Temple Hills Prince George's Maryland | 10g. Citizen of What Country? 10e. Street and Number USA 20748 Funeral #202 3055 Brinkley Road items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or iten edical Examiner r Black, White, etc Armed Forces 1 Never Married 2 Married Yes 2 X No Completed by White Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates er than "natur the Medical B 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Veterans Administratiop Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Administrative Assistant 18. Mother's Name (First, Middle, Maiden Sumame) Be 17. Father's Name (First, Middle, Last) Magliocco Frances ဂ Roma Felix 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8412 Penshurst Drive Springfield, VA Marlene English / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donarion 5 ☒ Other (Specify) Entombmen Clinton, Maryland Resurrection Cemetery 5/27/2011 22. Name and Address of Facility George P. Kalas Funeral Home ery ce Licensee Signat 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final HRONIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner MULTILOBAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Lect Due to (or as a consequence of) Examine MPTOMATIC To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) 9 | Linknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Investigation 2 Accident 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 only one) 29d. Date signed (Month, Day, Year) wre and title of certifie of death (Item 23a) (Type, Print) 502 (URRATTS . Date filed (Month State MAY 2 5 2011 Registrar

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			Registrar  1. Decedent's Name (First, Middle	e. Last)		Cer	uncate or i	Jeani		2. Date of Dea	Reg. No.		3, Time of Death		
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	Medio Examin		4a. Facility Name (if not institution			111	4b. City, Town, o	r Location		1147 249	4c. Count	of Donth	J		
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I		If Under 1 Year	If Under	r 24 Hrs.	8. Date of Birth	1	9. Birtl	nplace (State or Foreign		
	Director		579-12-8684	1 <b>本</b> M 2 □ F	91	Yrs.	Months Days	Hours	Min.	April I	5, 1920	Соц	DC		
7	MC T		Usual Residence of Decedent												
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Mo	28a notifi	Director	DC 10e. Street and Number						Washi				1 X Yes 2 ☐ No		
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200	or ite	by Ft	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 XMar</li></ul>	Armed F			Vas Decedent of H Yes, specify Cuba	an, Mexicai	n, Puerto R	lican, etc.)		ce - Amer ack, White	ican Indian, , etc.		
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ם קו	tal Hy doth even	To Be	17. Father's Name (First, Middle, I					18. Moth	ner's Name	(First, Middle, I	Maiden Surnan	ne)			
Baltimore, Maryland 21215-0036	shourd be fired within 7.2 frouts after death with the Maryland and Martal Hyglers.  7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	-		Gant					Cı	umie Ya	ncy				
Z Z Z	th and Men th and Men th and Men tranmatic		19a. Informant's Name/Relations				g Address (Street								
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ַסָר	nt of t: # it		1 XBurial 2 Cremation		n State	emetery, crem	natory or other plan	ce) y		ate 7 011	20c. Location	•			
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Ra Ra	Department of H Important: If its any injury or of		21. Signature of Funeral Service	te Ste	usut,		. Name and Addre		5-0	wart Fu E Wasl			, Inc. 20019		
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Spital	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying	Physician: To the I	best of my know	ledge, death o	ccured at the time	, date and	place, and	due to the cau	se(s) and man	ner as stat	ted.		
the Ho	nin 24 <b>he Fu</b> nplete	Medical	(Check 2 Medical E only one) 3 Certifying	xaminer: On the ba Nurse Practioner:	sis of examination To the best of m	n and/or invest y knowledge, d	gation, in my opinion eath occurred at the	on, death or e time, date	ccurred at the and place,	he time, date ar , an <mark>d due to th</mark> e	nd place, and di cause(s) and n	ue to the c nanner as s	ause(s) and manner stated. stated.		
10	To 1		29b. Signature and title of certifier	_		-	29c. Licens	e number	_	2	29d. Date signe	ed (Month	, Day, Year)		
				anne à	7		1) 7	56 50	06		May	23	,2011		
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	Stat Registra	e ar	31. Date filed (Month, Day, Year) <b>MAY 2 5 2011</b>	Server 32. F	Registrar's Sigla	ture	1								

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enry Lamont Gilbert State of Maryland / Department of Health and Mental Hygiene											
		1- For State Registrar		Certific	cate of Dea	ath ———			Reg. No.	<u> </u>	181/
Physicia Medical Exami		Decedent's Name (First, Midd     Hen	<sup>lle,Last)</sup> ry Lamont G	ilhert				2. Date of De Month May 23,	Day	Year	3. Time of Death 1430 hrs
)		4a. Facility Name (if not institution			4b. City	, Town, or Lo	cation of Death			c. County of Deat	n .
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Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last bir		nder 1 Year	If Under 24Hrs Hours Min	_	Birth (MM	Forei	thplace (State or
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any		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Location						10d. Inside City Limits
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5-0036 lled within 7 Hygiene.	징	17. Father's Name (First, Middle	, Last)			18.	.Mother's Name	(First, Middle	, Maiden	Surname)	<del> </del>
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	- 1	Flossie Gilber 20a. Method of Disposition	t - Mother		of Disposition (N			# 233 Date		Sningtor Location - City of	Town State
Baltimore, permit. Pages 1 an Department of He Important: If ite		1 Burial 2 Cremation	n 3 Removal from	State crema	tory or other plac	ce)	Tun	e 6.			·
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687 ertifica ding p	an/	23b. Was decedent pregnant in the past 12 months?	I Live bildi		2 Fetal dea	th 3	Ectopic pregna	incy			Day Year
Box 68760, edeath certificate be he attending physic defor use as the bur	Physician/Medic	1 Yes 2 No 9 Un	4 Pregnant		5 Other (S	pecify)					
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Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  *I Director: After this certificate has been signed by left fineral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	d by							1 🗌 Y	es 2	No 3 Pro	bably 4 Unknown
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J Of Jing Ph	崩	27. Manner of Death  1 Natural 5 Pen	28a. Date of I (Month, Da	njury 28b. y,Year)	Time of Injury	28c. Injury a	at Work?	28d. Describe	how inj	ury occurred	
Sior Attend death. ector:	ğ		stigation I d 3-1	8-11 fd Injury - At home, f	3:50 pm			Subjec	t wa	s cut a	nd stabbed _ ural Route Number, City
Divi pital or , ours after leral Dir filled in I	Certification:		la not be	Resteraun		ory, onice bank	aing, etc.	or Town,	State) 1	324 Cra	in Hgwy.
Gospit 4 hour Funer ely fill		29a. Certifier	hysician: To the best of			the time, date					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Medical	Ondon only	uminer: On the basis of each manner state	xamination and/or							
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ے ا		30. Name and address of person	who completed cause on the Medical Examir		Saltimore Str	eet Raltim	ore MD 21	223			
	ata	Ling Li, MD Assista 31. Date filed (Month, Day, Year)				- Dailiff					
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State 31. Date filed (Month, Day, Year)
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Oldio (	or maryia		tificate of		na Mentan		ag. No.			
Physicia Medical Exami	ın/	1. Decedent's Name (First							2. Date of Dear Month	Day Year	3. Time of Death 1305 hrs		
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		3035 Mandela C					Port Repu			Calvert			
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Director		215-58-9851	1_x	M 2 F	56	Yrs.	Worldis	lys Hours Will	06-09-1		CountryNew York		
any		Usual Residence of Dece 10a. State 10b. (	edent County		10c. City,	Town or Locati	on				10d. Inside City Limits		
<b>E</b>	5	Maryland C	alvert		Port	Republic					1 Yes 2 X No		
Maryla	Director	10e. Street and Number					10f. Zip Code			0g. Citizen of What			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		3035 Mandela	. Court	40 11/ 0			20676	li a di		United Stat			
eath w	Funeral	11. Marital Status  1 Never Married 2	2 Married	Armed Fo				lispanic Origin? ( S an, Mexican, Puerto		White, e			
after d	by F.	3 Widowed 4	X Divorced	1 Yes If Yes, Give Year or Dates:	2 X No	1	Yes 2X N	lo specify:		Specify:	white		
hours in maturi		15. Decedent's Education		y highest grade				ation (Give kind of ie. DO NOT use ret		16b. Kind of Busin	ess/Industry		
36 hin 72 e. than "	Completed	Elementary/Secondary	/ (0-12)	College (1-	4 or 5+)	steamf	itter			construct	tion		
21215-0036 July be filed within 7 Mental Hygiene, marked other than ic event, the Medica		17. Father's Name (First,	Middle, Last)					18.Mother's Name	Name (First, Middle, Maiden Surname)				
121 d be fil lental I	å	Francis Gi	fford		<u> </u>	T		Jean	Smullen er or Rural Route Number, City or Town, State, Zip Code)				
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e, N I and J Health item item	ı	20a. Method of Disposition	on		emetery June 3	Pate 2011	20c. Location - Ci	ty or Town, State					
Baltimore, permit. Pages I as Department of Hee Important: If ite		1 Burial 2 X Cr 4 Donation 5 C	_	_ Removal fro	Service	Alexandria Virginia							
Salti ermit. eepartm nports	j	21. Signature of Funeral		ee		22. N	ame and Addre	ss of Facility Rau	sch Funera	al Home PA			
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/Medical		failure. List only one Immediate Cause (Final	Disease	Between Onset and Death									
Examiner		or condition resulting in d			consequence of		LICIOLI	c oururo.	abcarar	DIBCOBC			
	<u>.</u>	Sequentially list condition if any, leading to immedia		ue to (or as a	consequence of	١٠							
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rted d ansit		events resulting in death)	) Last D d.	ue to (or as a	consequence of	):							
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed leath.  tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit	Medical	X UNPENDED		AMENDED 2	3a,27,p	er me,g	916 6-8	3-11 sm					
760, icate be g physical the buril		IF FEMALE: 23b. Was decedent pregna	ant in the	Comment of the Commen	utcome of pregn					23d. Date of de			
Box 687  e death certific  the attending p  ed for use as th	iciar	past 12 months?		1 Live bir	τη ınt at time of dea	ath —	aldeath 3 er (Specify)	Ectopic pregna	ancy	Month	Day Year		
e the G	Physician/	1 Yes 2 No 9	Unknown	9 Unknov					1				
P.O. Es that the congression of	ব	Part II. Other significant	conditions	contributing to	death but not re	sulting in the ur	nderlying cause	given in Part I.		2 No 3	te to the cause of death?  Probably 4 Unknown		
cords, Flaw requires has been sign 2 should be	Completed					· · ·			24a. Was a	an 24b. Wer	e autopsy findings available		
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tal Re	မ္မ	25. Was case referred to	medical			_	26.Plac	e of Death (Check		Z NO I V	Yes 2 No		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	2	examiner? 1 ✔ Yes 2 1	No Ho			ER/Outpatient				Residence 6 🗸	Other: Scene		
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SiO	2 Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number of										r Rural Route Number, City		
Divisi To the Hospital or At within 24 hours after d To the Funeral Direct		3 Suicide 6 Homicide	<ul><li>Could not be determined</li></ul>	(Specify)			,		or Town, S				
Ho Fu Fu		Torroat arry			-					e(s) and manner as			
To the within To the comple	Medical	one) 2 Medic 29b. Signature and title of	. 8	On the basis of and manner sta		d/or investigati		n, death occurred a	at the time, date a	and place, and due	(Month, Day, Year)		
		205. Orginature and title of	)					.M.E.		May 31, 2011			
	ŀ	30. Name and address of	person who co	mpleted cause	of death (Item :	23a)							
		Donna M. Vincer	nti, MD A	ssistant M	edical Exam	iner 900\	V. Baltimore	e Street, Baltin	nore, MD 212	223			
Sta Registi	-	31. Date filed (Month, Day	y, Year) V - 2 20		istrar's Signatur		Med			-			
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Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			se Type or Pri			<b>ndelible inl</b> artment of F			-	9.		
	_	For AMEND#5 per FH State Registrar 5/17/2011	AACO HEALTH DEI	•		rtificate of L		F	Reg. No. 2 1	1,12077		
Physicia Medic		1. Decedent's Name (First, Middle	A HAR	SH	BAR	GER		2. Date of Dea	Day 20	11 /02 PM		
Examin		4a. Facility Name (if not institution, Northwest Hospit	_	Hospi	ce		Location of Death		4c. County of De			
Funeral Director		5. Social Security Number 217–46–6594			st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			Sirthplace (State or Foreign Country) PA		
nd how at	5	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits		
Maryla 28a-f s otified	Director	MD Princ	ce George			Bowie				1 ☐ Yes 2XXXNo		
with the 23a or st be n	Funeral D	10e. Street and Number 13802 Heathers	tone Drive			10f. Zip Code	20720		10g. Citizen of What (	Country?		
death items		11. Marital Status	12. Was Decedent Armed Forces?			Was Decedent of H If Yes, specify Cuba	ispanic Orlgin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 2 Marr 3 Widowed 科基 Divorced	ied 1 ☐ Yes <b>2√2</b> If Yes, Give Year or Dates.	No		1 ☐ Yes 2X1X1 No	Specify:			White		
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be filec antal H ked otl	.0	17. Father's Name (First, Middle, L Wellington Ecker	,					ne (First, Middle, I Schafer	Maiden Surname)			
2 should th and Me 27 is mar traumati		19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street			; City or Town, State, .	Zip Code)		
and 2 s Health em 27 ther tra		Benton Harshbar	rger Son			Heathers	tone Dri	- · ·	Le, MD 207			
Page 1 nent of 1 ant: If it ury or o		1 ☐ Burial ※※ Cremation 4 ☐ Donation 5 ☐ Other (S		, Ce	metery, crer	matory or other place Cremato		Date 3/2011	Glen Burn:			
permit. F Departm Importa any inju once.		21. Signature of Funeral Service L	ensee		22	2. Name and Addres	ss of FacilityHar	desty Fu	neral Home	e, P.A.		
TD = 46 0		23a. Part 1. Enter the disease, or	complications that cause	d the death		2 Ridgely er the mode of dyin			s, MD 2140	Approximate		
Physician/		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one caus son each lin	b (	Rec	eta Rl	1 1	sead	0	Interval Between Onset and Death		
Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a consequ	ence of):							
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cate be e physiciar the buris	dical		d									
eath certificate be attending physicaters of for use as the beat t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of <u>pr</u> egnar	ncy				23d. Date of	delivery		
the atter	by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1  Live Birth 4  Pregnant a			Ctopic pregnand Other (specify)	Cy .		Month	Day Year		
requires that the de been signed by the should be detached	by Ph	Part II. Other significant condition	ns contributing to death I	out not resu	ılting in the u	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
requires	eted							1 🗆 1		Probably 4 Unknown  autopsy findings available		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	Completed							24a. Was a autop perfor	rmed? prior t death	o completion of cause of		
sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	·	-D/O 1 - 1 - 1	Oth	ace of Death (Che		he	of pict		
ng Phy fter this meral d	ite: To	27. Manner of Death  1 Natural 5 Pendin	28a. Date of inju	ırv	28b. Time of injury	nt 3 LI DOA	4 ∟ Nursing F y at		lence 6 Other So ow injury occurred	ecity)*		
Attendi death. ctor: A	Certificate;	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	pation not be 280 Place of Ini	urv - At hoi	ne. farm. str		Yes 2 ☐ No	28f. Location /S	treet and Number or I	Rural Route Number.		
ital or / urs after ral Dire		4 ☐ Homicide determ	building, et	c. (Specify)				City or Tow	n, State)			
n 24 hou n 24 hou le Fune pleted fii	Medical	(Check 2 Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or inves	stigation, in my opinio	on, death occurred	at the time, date ar	nd place, and due to th	e cause(s) and manner stated.		
To th Within To th		29b. Signature and title of certifier		1	100	29c. License			29d. Date signed (Mo			
		30. Name and address of person v	who completed cause of	eath (Item	23a) (Tyne-F	Print)	58/0	< /K	10,	2011		
50		mon	BC3 6	930	9 4	v, agb	m 31	nd Ste	n Surny	2406/		
Stat Registra	_	31. Bate filed (Month, Day, Year)	2011 32 Registr	ar's Signati	1. 40	well						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month\_ Year Zoll Physician/ George Edward Hollerman Jr. Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Regionii MCCICUI CONC 8. Date of Birth (Month Day, Ye April 1 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) Country) Jew Jersey **Funeral** Days Hours Year) 1.1929 1 🗶 M 2 🗆 F 218-24-4757 82 New Director Usual Residence of Decedent 10d. Inside City Limits items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No MD Dorchester East New Market 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 5646 Springdale Road 21631 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 X Yes 2 □ No "natural", or 1 Never Married 2 X Married þ Maryland 21215-0036 white 1 ☐ Yes 2 🕱 No Specify: rr Yes, Give Year or Dates. 1948–52 If Yes, Give 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) can mfg. quality control inspector Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen Clark George E. Hollerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5646 Springdale Rd., East New Market, MD Sylvia B. Hollerman wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/23/11 Woodlawn Mem. Park Easton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MON disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** soiraton Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Day in the past 12 months? Month Year Yes 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death? 1 Yes 2 No Yes 2 No To the russymmer within 24 hours after death.

To the Funeral Director. After this certifical in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1100 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 1 Tes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certi 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XB aH MA Carroll

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death SYED TASAWAR Month Physician/ 2011 HUSSAIN 9:48 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOWARD HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Birthpia Country) India **Funeral** 1 **x** M 2 □ F Hours Min (Month, Day, 66 215 39 2440 Director May 1945 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City 1 Yes 2 X No Md Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21042 9700 Robert Jay Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Asian Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Plus Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nabi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iqbal other traumatic Sved Zahoor Hussian 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 9700 Robert Jay Way, Ellicott City, Shaheen Hussian. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
[aryland Nat Cemetery 5/23/1] Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Laural Maryland uneral Service Lice 22. Name and Address of Facility Hall Brothers Funeral Home <u>Florida Avenue. NW. Wash. D.C. 20001</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Metastolic Rancer Onset and Death Immediate Cause (Final Pantreatie Physician/ disease or condition resulting in death) Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23h Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Yes 2 No a Unknown 9 Unknown been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes melletus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hyperleumon 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed 2 🗌 No 2 1 N Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dempatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation Funeral Director: eted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, irring opinion, seems of examination and/or investigation, irring opinion, seems of examination and or investigation and or investigation and or investigation, irring opinion, seems of examination and or investigation a 29b. Signature and title of certifier

Nushymanial, MD 29d. Date signed (Month, Day, Year) MD 61504 MAY 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHANLAL, 5755 CEDAR LANE, COLUMBIA, MD

Registrar DHMH 17 Rev 7/2009

State

NAY 2 5 2011

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mon 8:05 PM Rita A. Hollingshed 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 5, 1953 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** Min 1 M 2 X F Days Hours Country) Director 577-76-8557 57 Usual Residence of Decedent 28a-f shov ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3531 Jay Street NE 20019 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Housewife Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert J. Hollingshed Camilla E. Danzy 19a. Informant's Name/Relationship (Type, PrintHusband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20019 3531 Jay Street NE # 104 Washington, DC Linwood Davis / Common - Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 201 ī 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Holm 4001 Benning Road NE Washington, DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician irrhosis disease or condition Medical resulting in death) *≸*Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events Acute vena burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 No After this certificate 2 🗌 No 1 Tyes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA
Date of injury 28b. Time of 28c 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) 1 💢 Natural 5 Pending death. after death Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature 2011 DS5220 completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly Maryland 20785

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day

MAY 2 5 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per DH g916 6/17/2011 JH
State of Maryland / Department of Health and Mental Hygiene 1

For State Registra Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2011 Month May **Physician** 17, 0759 Anthony Tyrone Hillman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly | If Under 1 Year | If Under 24 Hrs. | Min. | Nov. | 2, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Yrs. DC 60 Director 578-66-4942 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28a-f show th and Mantal Hygiene. 27 is marked other than "natural", or Items 23a or 28a-1 ehor traumatic event. It a Medical Examinar must be notified at 1 XYes 2 ☐ No Oxon Hill Directo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20745 United States 5016 Lelend Drive Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4or 5+) none unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked other Helen Wheeler Wardell Hillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20144 Nina Hillman Smith- Daughter 1910 Arwell Court Severn, Maryland other June DOI , 2011 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition TEE's Crematory May 28, Tabunal 2 Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ö Clinton, Maryland permit. Page Department of important: If eny injury or once. 2011 Washington, Glenwood - Cemetery 21. Signature - Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCHEROTIE ARXIOVASCULAR **Physician** 1-01213 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by HUMAN IMMUNO DEFICIENCY VIZUS CARDIA ARREST 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Hemodialiss ENCEPHALOMETRY 24a. Was an has autopsy performed? Respiratory Failure certificete Ventilater Dependent Hepititis C 2 🗆 No 1□ Yes 3□No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. To the Funerel Director; completely filled in by the t 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a Hospitei 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 17 2011 30. Name and address of person who/completed cause of death (Item 23a) (Type, Print) VORE MD 4203 QUEENSBURY 31. Date filed (Month, Day, Year) MAY 2 5 2011 32. Register's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 25<sup>Day</sup> Physician/ Month 05 2011 2:25 рМ William Frances Hetrick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett 0akland 25 Fern Drive 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year Months Days Hours Min. Country) 1 M 2 D F 01 Director 89 192 177-18-8111 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10a. State 10b. County Examiner must be notified at Director MD Garrett 1 Tes 2 No 0akland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 21550 25 Fern Drive USA items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 \( \subseteq \text{No} \) Black, White, etc. 1942 ģ 1 Never Married 2 Married ō 72 hours after Baltimore, Maryland 21215-0036 USA 1 Yes 2 No If Yes, Give Year or Dates 1946 Specify "natural", 3 -Widowed 4 - Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72... th and Mental Hygiene. ?7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) electric 12 foreman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Cramer Archibald Hetrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Deborah Hetrick-daughter Oakland, MD 21550 Fern Drive, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State North Braddock, PA Monongahela Cemetery 4 Donation 5 Other (Specify) 5/27/2011 22. Name and Address of Facility David A. Burdock Funeral Home PA . Signatur Funeral Service Licensee N 2nd St, Oakland, MD 21550 Parf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Daath Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit and Due to (or as a consequence of): ŵ certificate has been signed by the attending physician irector, page 2 should be detached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 Tes Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other 5 Residence 6 Other (Specify) 2 **2**No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Coerthyipg Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2

To the F only one) 29d. Date signed (Month, Day, Year, 29b. Signature and Affle of D23979

WAT

State Registrar Robert A. Goralski, M. 31. Date filed (Month, Day, Year) 32.

M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. parl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Johnnie D. Hardison May 19, 2011 18:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Feb. 3, Year 1933 Months Days Hours Min. Director 246-40-0820 78 North Carolina Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12510 Epping Court 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian an "natural", or ite Medical Exaπiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) event, the 12th General Office Work Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F 2 Herbert Hardison Sr. Hannah E. Henderson and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willa D. Salley - Daughter 1108 Bradford Ridge Lane Columbia, SC 29223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
Quantico
ational Cemetery Burial 2 ☐ Cremation 3 ☐ Removal from State May 26 2011 4 Donation 5 Other (Specify) National Triangle, Virginia 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Ligense 6 4001 Benning Road NE Washington, DC 20019 23 Pr.t.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Interval Between mmediate Cause (Final Physician/ Aspiration Pneumonia weeks disease or condition Medical resulting in death) **Examiner** Alzheimers Dementia years Sequentially list conditions, Examine If any Iracing to immedicause. Enter Underlying Cause (Disease or iinjury burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Order (specify) \_\_\_\_ IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 1 ☐ Yes 2 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease, Prostate Cancer Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? Dysphagia 24a. Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred al or Attending F s after death. I Director; After work?
1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Aupanich RSM MD D 0065485 05/20/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, Maryland 20910, Barbara Supanich, RSM, MD 1500 Forest Glen Road State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gerald A. Haddaway May 2011 :20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🌠 M 2 🗆 F Months Days Hours Min 0770171930 Director 80 MD <u> 217-24-8883</u> Usual Residence of Decedent Show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f M 1 🗌 Yes 2 🔀 No Howard Ellicott City 10e. Street and Number ö 10g. Citizen of What Country? Examiner must be 23a Funeral 9857 Helmwood Court 21042 United States items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. or þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Specify: 3 X Widowed 4 □ Divorced White Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Auto Industry Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည Gerald Alexander Haddaway Emily Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 si tment of Health a item 27 Cynthia Haddaway Stitz - dau. 10366 Tuscany Road Ellicott City, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of h Important: If ite 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 05/27/2011 Marriottsville, MD Crest Lawn Mem. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc any 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Weeks Physician/ Aspiration pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dysphagia unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Subcortical cerebrovascular accident unknown that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ☐ Live Birth 2 ☐ Fetal deat
☐ Pregnant at time of death ō Month Day Year hed g Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 atrial fibrillation, myocardial infarction 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law nas page 2 autopsy performed this certificate | 2 No Yes 2 X 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6 $\overline{\mathbf{X}}$  Other (Specify) Hospice 1 🗌 Yes မ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 XNatural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: A 2 Accident
3 Suicide
4 Homicide Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Detrifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, R145356 May 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 Rebecca Sutula 555 West Towsontown Blvd. Towson, MD distrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cynthia Vanessa Lilley Denson Hargis Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 100MICO TONINSULA Birthplace (State or Foreign Country)
 NC If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** Days Months July 27, 1954 1 🗆 M 2 🔀 F Hours 059-44-1066 56 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner must be notified an once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Funeral Director 1 🔀 Yes 2 🗆 No MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21801 28249 Canterbury Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo
If Yes, Give
Year or Dates. Black, White, etc.
African-1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 TDivorced American 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Educator/Psychologist 8+ Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 L. Camilla Copeland James I. Lilley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28249 Canterbury Dr., Salisbury, MD 21801 Benjamin Denson/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Green Acres Mem Park May 21, 2011 Salisbury, MD 4 Donation 5 Other (Specify) Signatur — uneral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA abson 1618 West Rd., Salisbury, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Efetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Other (specify) Pregnant at time of death Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No After this certificate Yes 2 To the Funeral Director: After this certific completed filled in by the funeral director, 25 Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 100 HILDMANN egistrar's Signatu 31. Date filed (Month Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 18086 State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Huamani MMay 13° 2011 Year Juana Agripina 0956 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Olney Montgomery Montgomery General Hospital If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign ocial Security Numbe 7. Age (In yrs. last birthday) 215-39-8597 1 🗆 M 2 🗀 🕏 Peru 1407094/4921 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Silver Spring 1 🗌 Yes 2 🖁 No MD Montgomery 10f. Zip Code 20904 10e. Street and Number 10g, Citizen of What Country? 700 Rosemere Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 🖫 Yes 2 □ No Specify Peruvian White If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Choque Benjamin Zagarra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20853 15001 Flower Valley Court Rockville, Md. Miquelina C.Jones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 KBurial 2 ☐ Cremation 3 ☐ Bemoval from State 5/16/2011 Silver Spring, Md. Gate of Heaven 4 Donatio 5 Other (Specify Fungal Service Liversee 21. Signature PHTETPAdres RENIALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a neu M Due to (or as a consequence of)

Physician/ Medical Examiner Examine

Physician/

Medical

**Examiner** 

**Funeral** 

Director

or 28a-f show notified at

Director

Funeral

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Completed

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy 23d. Date of delivery

r use as the burial-transit law requires that the death certificate be executed attending physician for use as the burial. P.O. Box 68760 ate has been signed by the a page 2 should be detached Division of Vital Records, To the Hospital or Attending Physician: The lwithin 24 hours after death.

To the Funeral Director: After this certificate h the funeral director, сотріете filled in by

Be Completed by Physician/Medical

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Certificate:

Medical

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1	Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No 1 □ Yes 2 □ No	
25. Was case referred to medical	26. Place of Death (Chec	ck only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	lome 5 Residence 6 Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigat		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier only one) Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Signature

30. Name and Rapha

Prince P

State Registrar 31. Date filed (Month, Day, Year) MAY 20

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

1355 Piccard Dr, Rockville, Md. 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Geoffrey Coleman,

MAY 20 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald P. Hanna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth Birthplace (State or Foreign **Funeral** Month, Day, Year) August 12, 1928 1 **X** M 2 □ F Months Hours 82 Ohio Director 215-20-7030 Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be n ō 10g. Citizen of What Country? 334 Allegany Street Funeral U.S.A. 21532items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 I of Health and Mental Hygiene. If item 27 is marked other than "r r other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Sales Store Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Pearre Hanna Ruth Foye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Hanna Wife 334 Allegany Street Maryland 21532-Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Memorial Park May 18, 2011 Frostburg Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olin Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown isigned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To I\_☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, ss of person who completed cause of death (Item 23a) (Type, Print) YAMAR 31. Date filed (Month, Day, 82. Registrar's Signature Year) State MAY 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03701 State of Maryland / Department of Health and Mental Hygiene Okasha Montrey Hawkins 1- For State Certificate of Death Rea. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 17, 2011 OKASHA MONTREY HAWKINS
MONTRE

4a. Facility Name (if not institution, give street and number) Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death Forest Heights Prince George's 5600 Ottawa Street 9. Birthplace (State or Foreign WASHINGION, DC If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Director MARCH 10,1989 219-23-8198 1 X M 2 F 22 Usual Residence of Decedent 10c. City, Town or Location FOREST HEIGHTS MARYLAND PRINCE GEORGES within 72 hours after death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number UNITED STATES 20745 603 MODOC LANE 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 X Never Married 2 Married 2 X No Yes Specify: BLACK 1 Yes 2 X No specify: If Yes, Give Year 3 Widowed 4 Divorced <u>Ş</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 ho. Department of Health and Mental Hygiene. Important: If item 27 is marked other theminjury or other traumaria. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) FAST FOOD RESTAURANT ASSISTANT MANAGER 12TH GRADE Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KATHY THEODORIA KEYS BERTRAND ELLIOTT HAWKINS Be 19a, Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 603 MODOC LANE, FOREST HEIGHTS, MARYLAND 20745 KATHY T. KEYS / MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HERITAGE MEMORIAL CEM MAY 21,2011 WALDORF, MARYLAND 4 Donation 5 Other Specify 21. Si nature of Funeral Service Lic Z. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, THORNTON JOHNSON MOO583 LADIA C. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial - transi Physician/Medical \* AMENDED Item 1, per me, g916 6-6-11 sm UNPENDED Box 68760, 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown ě Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed ✓ Yes 2 No 1 Yes al or Attending Physician: T s after death. I Director: After this certific 25. Was case referred to medica 26.Place of Death (Check only one) of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Certification: May 17, 2011 Subject shot 0210 hrs Natural 1 Yes 2 ✔ No 5 Pending the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) 5600 Ottawa Street, Forest Heights, MD within 24 hours a To the Funeral I determined (Specify) Field 4 V Homicide

0225 hrs

10d. Inside City Limits

1 Y Yes 2 No

MARYLAND 20640 Approximate Interva

Dav

29d. Date signed (Month, Day, Year)

May 17, 2011

Between Onset and

Death

2 No

12B3

**ORIGINAL** 

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only)

and manner stated

Assistant Medical Examiner

29b. Signature and title of certifier

Theodore M. King, Jr., MD 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

**OCME** 

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Month Physician/ Johnson Esther Lorraine 18. May 1300 hrs♪ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville 9. Birthplace (State or Foreign Birth , Day, Year) 22 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, 1944 1 □ M 2 🗶 Washington, D.C. 66 Yrs 577-58-5904 November Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1X Yes 2 No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number United States Funeral 20800 20882 Zion Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc. ò 1 X Never Married 2 Married 2 **X** No **Black** 1 ☐ Yes 2 X No Specify. If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Walter Reed Army Elementary/Seconday (0-12) College (1-4 or 5+) Medical Center Recreational Aide 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Queen Johnson Esther (unknown) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20032 800 Southern Avenue, S.E.; Apt. 904; Washington, D.C. Taniya Denise Johnson Wilson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May 27,2011 1 Burial 2 X Cremation 3 Removal from State Riverdale, Maryland 4 Donation 5 Other (Specify) Riverdale Park Crematory 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Servi Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratoru disease or condition resulting in death) Due to br as a consequence tive Pulmonary Disease Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🕷 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Pregnant at time of death 1 ☐ Yes ∠ v 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the hundurance. Division of Vital Records, P.O. Box 68760

**Funeral** 

Director

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ems 23a or 28a-f shorms must be notified at with the Maryland

ral", or items 2 Examiner mus death 1

or other traumatic event, the Medical

and Mental Hygiene.

Pnysician/

Medical

Examiner

Baltimore, Maryland 21215-0036

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State

work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number

DOG 6450 Z

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901 Medical Center Drive, Rockuille, 20850

32. Registrar's Signature Date filed (Month, Day, Year) 2 5 2011

Registrar

Medical

(Check

	-1	s, per FD, Pleas gany County - State - State		•	Certifica	te of L	Death		leg. No.2 0	11 18091
Physician	/	Registrar  1. Decedent's Name (First, Middle, L	,	d Ann Jaco				2. Date of Dear		3. Time of Death
Medica Examine	_	la. Facility Name (if not institution, gi	ve street and number)	Medical Ce		y, Town, or	Location of Death	berland	4c. County	of Death Allegany
Funeral Director		i, Social Security Number 6.		ge (In yrs. last bir		er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apri	Year) 129, 1924	9. Birthplace (State or Foreign Country) Maryland
	- 1	Usual Residence of Decedent  10a. State  10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
e Marylar r 28a-f s notified	Funeral Director	Maryland	Allegany		Inf :	ip Code	Frostburg		10g. Citizen of \	1 X Yes 2 □ N What Country?
h with th	neral		skirk Hollow R				21532			USA
after deatl		<ul> <li>1. Marital Status</li> <li>1 ☐ Never Married 2 ☐ Married</li> <li>3 ☒ Widowed 4 ☐ Divorced</li> </ul>	If Yes, Give	2			ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		e - American Indian, ck, White, etc.  White
72 hours "natura edical E	Completed by	15. Decedent's (Specify only highest		168	a. Decedent's Us (Give kind of v life, DO NOT u	rork done d	ation during most of work	ring	16b. Kind of B	usiness Industry
ygiene. her thar nt, the M	a F	Elementary/Seconday (0-12)	College (1-4 or		IIIe. DO NOT	56 1611160)	Homemaker	(Fig. 4, 5, 6; -1-1)	Mariata a Communication	Home
d be filed Mental H arked ot atic ever	일 일	17. Father's Name (First, Middle, Las	Gilbert Emn		merick		18. Mother's Nam		Lillian Le	oar
oermit. Page 1 and 2 should be filed within 72 hours after Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examone.		19a. Informant's Name/Relationship  Carol Crov	(Type, Print) we - Daughter	19				Road SW,		State, Zip Code) Maryland, 21532
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1	Removal from State	cemete	of Disposition (Nery, crematory of rostburg M	r other plac	ce) Park	May 21, 2011		- City or Town, State rostburg, Maryland
		21. Signature of Funeral Service Lice			22. Name		ss of Facility East Main Str			nzie Funeral Home P MD 21539
Pnysician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ed the death. Do ne. ///////////////////////////////////	2DIA	ode of dyir		or respiratory arr		Approximate interval Between Onset and Death
2 - 10	dical Examiner	Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	C	s a consequence						
he death certifica y the attending pl ched for use as ti	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal dea at time of death			су			ate of delivery onth Day Year
	॒	Part II. Other significant conditions			in the underlying	g cause gi	ven in Part I.			tribute to the cause of death?  3  Probably 4  Unknow
uires that t signed b lid be deta	g p	1111201	ENSIO,	<u> </u>				1 🛮	tes 2. Ino	3 - Probably 4 - Clikilov
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sician: The law requires that t certificate has been signed b irector, page 2 should be deta	m	25. Was case referred to medical examiner?	Hanital		Nutratient 3	LOW	lace of Death (Che	24a. Was autoperfor 1 Yes	an 24b. osy rmed? 2 No	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
ding Physician: The law requires that th. After this certificate has been signed b funeral director, page 2 should be deta	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manny of Death  1 Natural 5 Pending	Hospital: 1 Inp. 28a. Date of ir	atient 2 ER/C	Outpatient 3 Time of injury	DOA Oth	ner: 4  Nursing H	24a. Was autor performent of the second seco	an 24b. osy rmed? 2 No	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
or Attending Physician: The law requires that tafter death.  Director: After this certificate has been signed be in by the funeral director, page 2 should be deta	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manny of Death	Hospital: 1 Inp.  28a. Date of ir (Month, E)  28e. Place of I	atient 2 ER/C	Time of injury	DOA Oth 28c. Injury wor 1	ner: 4 Nursing H ry at k?	24a. Was autor performence of the performance of th	an ssy med? 24b.  Jence 6 Oth own injury occur	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Hospital or Attending Physician: The law requires that the death certificate b 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physicated filled in by the funeral director, page 2 should be detached for use as the b	Certificate: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manny of Death 1  Natural 5 Pending Investiga 3  Suicide 6 Could no determin  29a. Certifier 1 Certifying P	Hospital: 1 Inp.  28a. Date of ir (Month, E)  28e. Place of Ibuilding, 6  Physician: To the best company on the basis of	atient 2 ER/C  jury lay, Year)  28b.  njury - At home, 1  etc. (Specify)	Time of injury M farm, street, fac	28c. Injui wor 1 cory, office	er: 4 Nursing H y at k? Yes 2 No  e, date and place, a ion, death occurred	24a. Was autor performence of the performance of th	an ssy med? 24b.  Jence 6 Oth ow injury occur  Street and Numb.  Street and Numb.  use(s) and maning place, and dil	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No  ner (Specify)  red  per or Rural Route Number,  ner as stated.  Just to the cause(s) and manner states.
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director.	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manny of Death 1  Natural 5 Pending Investiga 3  Suicide 6 Could no determin  29a. Certifier 1 Certifying P	Hospital:  1 Inpa  28a. Date of ir (Month, E  28e. Place of I building, 6	atient 2 ER/C  jury lay, Year)  28b.  njury - At home, 1  etc. (Specify)	Time of injury M  farm, street, fact, death occurred/or investigation, wiedge, death oc	28c. Injui wor 1 cory, office	ter: 4  Nursing H ry at k? Yes 2  No e, date and place, a tion, death occurred ne time, date and place	24a. Was autor performence of the performance of th	an psy 24b.  Street and Number Notate)  street and Number Notate)  suse(s) and manual place, and due cause(s) and manual descriptions.	Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No  ner (Specify)  red  per or Rural Route Number,  ner as stated.  Just to the cause(s) and manner states.
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detailed.	Certificate: To Be	25. Was case referred to medical examiner?  1	Hospital: 1 Inp.  28a. Date of ir (Month, E)  28e. Place of Ibuilding, 6  Physician: To the best company on the basis of	atient 2 ER/C  Juny 28b.  Injury - At home, 1  etc. (Specify)  of my knowledge  f examination and ne best of my know	Time of injury M farm, street, fac death occurector investigation, wledge, death occured to the street of the stre	28c. Injuryor 1 Cory, office at the time in my opin courred at the correct at the	ter: 4  Nursing H ry at k? Yes 2  No e, date and place, a tion, death occurred ne time, date and place	24a. Was autor performence of the performance of th	an psy 24b.  Street and Number No. State)  use(s) and manual place, and die cause(s) and manual die ca	Were autopsy findings available prior to completion of cause of death?  1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State State Amended#23a(a)per Registrar	e of Maryla MD FCHD	nd / Depa KS 5/24	artment of F	lealth ar Death	nd Mental Hy	giene		
Physi	ician	/	1. Decedent's Name (First, Middle, Last)  Sharon Lee King					2. Date of De Month May	ath	01 <sup>Year</sup>	3. Time of Death 7:25 A M
Me Exar	dica nine		4a. Facility Name (if not institution, give street and	number)		4b. City, Town, or	Location of I		4c. Count	y of Death	
	F		136 W. Orndorff Drive  5. Social Security Number   6. Sex	7 Age (In ure	last histoday	Brun	swick	Hrs. Lo. D. L. (D)		rederi	
Fune Direct			213-66-2187 1 □ M 2 🗵	_	. last birthday) 57 Yrs.	Months Days		May 1,60 May		9. Birthp Mary	lace (State or Foreign $\Upsilon^{\!\!\!\!p}$ and
and show	٦	. r	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loc	cation				10	Od. Inside City Limits
Maryla 28a-f :		Irect	Maryland Frederick		Bru	nswick					1 🛭 Yes 2 🗆 No
with the 23a or		<del>≂</del> l	10e. Street and Number 136 W. Orndorff Drive			10f. Zip Code 2171	.6		10g. Citizen of Uni	What Count	•
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		à	1 Never Married 2 Married Armed	ecedent Ever in L Forces? es 2 🛣 No	l II	Vas Decedent of Hi FYes, specify Cuba	n, Mexican, F	? (Specify Yes or No- uerto Rican, etc.)	Bla	ce - America ack, White, e y: <b>Whit</b>	tc.
5-00; hours a natural ical Ex		eted	15. Decedent's Education	r Dates.		lent's Usual Occup			16b. Kind of E		
1215 thin 72 ne. than "r		Completed		te <i>d)</i> e (1-4 or 5+)	(Give F	kind of work done of NOT use retired)	luring most of	working		n Home	
nd 2:		å l	12 17. Father's Name (First, Middle, Last)			Homemake	18. Mother's	Name (First, Middle,	Maiden Suman		=
rylar uld be 1 Menta narked		۵	Frank Robert Strunk				Hele	en M. Lied	ing		
Baltimore, Maryland 21215-0036 cernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", on any injury or other traumatic event, the Medical Exami		1	19a. Informant's Name/Relationship (Type, Print)  John E. King, Jr. / Hus	sband				r Rural Route Numbe , Brunswic			ode)
Ore, ge 1 and t of Hei If item or othe		1	20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Removal for	20b.	e)	Date	20c. Location	- City or Tov			
Iltim nit. Pag artmen ortant: injury	e)		4 Donation 5 Other (Specify)  21. Signatu 1 Funeral Se vice License	N		Gardens		y 19, 2011			
Per Dep any	ouce	4	My		tin Mou	l Services ıntain Hwy	. Frede	rick,	P.A. MD 21701		
Physicia Medic	al		disease or condition	nat caused the dea n each line. bable sumed My to (or as a conse	diac or respiratory ar	rest,	1	Approximate Interval Between Onset and Death minutes			
Examin		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due	to (or as a conse	quence of):					_	
cuted nd ransit			cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.		400100 01/1						
60 ate be executed hysician and the burial-transit		OICAI E	resulting in death) Last Due	to (or as a conse	quence of);						
8760 tificate by ng physic as the b	3	Med	F FEMALE:								
Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate be executed rs after death. al Director: After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transit		iysicidi.	23b. Was decedent pregnant 23c. If yes, in the past 12 months? 1 ☐ L 1 ☐ Yes 2 🔀 No 4 ☐ F	outcome of pregr ive Birth 2  Fe regnant at time of Inknown	etal death 3 🗌	Ectopic pregnanc Other (specify)	у			ate of deliver onth I	ry Day Year
ords, P.O. B. requires that the de been signed by the should be detached			Part II. Other significant conditions contributing				en in Part I.	23e. Did to	obacco use con	tribute to the	e cause of death?
rds, require been sign		nala	Obesity, Hyperlipidemi	a, Hyper	tension						ably 4 Unknown
fital Reco sician: The law certificate has birector, page 2 s		complete by							osy rmed?		sy findings available npletion of cause of
Vital F ysician; T is certifica director, p		2	25. Was case referred to medical examiner?					1 🗌 Yes Check only one)	Z LAL NO	T La res	z 🗆 NO
of VI g Phys er this c			27. Manner of Death 28a. D	Inpatient 2 [ate of injury fonth, Day, Year)	28b. Time of	28c. Injury	4 <u> </u>	ng Home 5 🐼 Resid			
rision or Attending I er death.			2 Accident Investigation		injury		Yes 2 No	_			
Divis pital or Att ours after d eral Direct				ace of Injury - At h iilding, etc. (S <i>peci</i>		et, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	oer or Rural F	Route Number,
To the Hospital of within 24 hours a To the Funeral D completed filled in	Modian	Medica	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination	on and/or investi	gation, in my opinio	n, death occur	rred at the time, date a	nd place, and du	e to the caus	se(s) and manner stated.
To i		1	29b. Signature and title of certifier	ante		29c. License	number 0056890	=	29d. Date signe May 18		
L)			30. Name and address of person who completed o	ause of death (Ite		rint)			nay 10	, 201.	•
	tate		Caroline Gessert, M.D.  31. Date filed (Month, Day, Year) 32	610 9t 2. Registrar's Sign	ature	Brunswic	ck, MD	21/16			
Regis		-	MAY 19 2011	Busenes	100	barkal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 26 per med cert C916 6/20/11 dk.
State of Maryland Department of Health, and Mental Hygiene
AMEND TEM#194, b, per INF, C919, 9/27/2011, WS

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, 2011 5:40 PM Patricia Gwen Klaes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Tate Hospice House Linthicum Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day Ine 26 1 □ M 2 Ϊ Days Yrs Tennessee **Director** 228-84-9816 46 1964 June Usual Residence of Decedent 28a-f show 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No |Maryland|Anne Arundel Severn ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 1517 Wyncote Circle 21144 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ō ģ 1 Never Married 2 X Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates "natural", Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Non Profit other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Marie Wickline James William Davis 191 Saling Address (Street and Number of Rural Severing City or Town, State, Zip Code)
2019 Aberdeen Drive Crofton, MD 21114 19a Informant's Name/Relationship (Type, Print) August Clair Klaes, Jr./Husband Ellen R. Schramm/ Sister permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is n 20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington 5/17/2011 Laurel, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) 12 CODY Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on death certificate be executed and -trans resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Year Day Pregnant at time of death 5 Other (specify) 1 Yes 2 Dunknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ' autopsy performed Yes 2 No page 2 this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 K Other (Specify) hospice 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Natural 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier May 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S- Hanovar St. Baltimore MD 21275 ,3001 VON BEND, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 172011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Physician/ 8:00 Frederick Adam Keller Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery General Hospital 01ney Montgomery . Social Security Number . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days 1 ፟፟፟ M 2 □ Months Hours (Month, Day, Ye Country) Director 86 Yrs 1925 089-14-2430 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4544 Minuteman Drive 20853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: SpecifyWhite 3 X Widowed 4 ☐ Divorced Completed Year or Dates. WWII Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Communications Satellite Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adam Keller Clara Eberhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Keller/Son 4544 Minuteman Drive, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 19 2011 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Etropolitan Crematory Alexandria, VA Signature of Funeral Servicens 22. Name and Address of Facility
Francis J. Collins Funeral
500 University Blvd. W., Si Home Inc. 1ver Spring. MD 20901 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ⊬h, sician/ Hspiration disease or condition resulting in death) Theymonig Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of eremia 24a. Was an has autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case ref-rred to medical 26. Place of Death (Check only one) examiner r 1 ☐ Yes 2 No Hospital Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 📕 Inpatient 2 🗌 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No injury 5 Pending death. Accident Investigation after death the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29c. License number 29d. Date signed (Month. Day, Year) H. A. Meranov D0071314 8+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Drive Olney (Month, Day, Year) State MAY 20 2011 Registrar

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 230 Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown North West Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Min Month, Day, Yea March 14, Year) 50 1961 DC **Director** 578-90-8213 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits the Maryland must be notified at Director 1 X Yes 2 ☐ No Maryland Prince George's Laure1 10f. Zip Code ŏ 10e, Street and Number 10g. Citizen of What Country? 23a Funeral within 72 hours after death with 13182 Larchdale Road #3 20708 <u>United States</u> items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black White etc. 1 Never Married 2 Married "natural", or <u></u> Baltimore, Maryland 21215-0036 <sub>Specify:</sub>African American If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Plummer Jaqueline Williams Department of Health and Important: If item 27 is n any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13182 Larchdale Road #3 Maddox Lee - Husband Laurel, Maryland 20708 20a. Method of Disposition 20b. Place of Disposition (Name of Date 7 28, 2011 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗀 Removal from State May Landover, Maryland 4 Donation 5 Other (Specify) Harmony 22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service Lichs e 20019 4001 Benning Road NE Washington, DC 234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Neuroena disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or) il any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown ned by the a 9 Unknown signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No Yes 2 🔀 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Spe 1 Yes Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA nin 24 hours after death.

the Funeral Director: After this on pleted filled in by the funeral dir 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 1 ☐ Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death as well as the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier who completed cause of death (Item 23a) 93 Date filed (Month, Day, Year) State MAY 2 5 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 25 05 2011 1:30 p M John Richard Michaels /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 891 Joni Miller Road 0akland Garrett 8. Date of Birth (Month, Day, 03 22 Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 M 2 □ F 72 1939 Director 215-34-8164 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, I'm Medical Evaminer must be notified at 1 ☐Yes 2 No Director MD0akland Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 891 Joni Miller Road 21550 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 building carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any Injury or other trainment John H. Michaels Edna Mae Cline ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joni Miller Road, Oakland, MD 21550 Kathryn Michaels-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pleasant Valley Cemetery 5/28/2011 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oakland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA 21. Signature of Funeral Service Licensee 21 N. 2nd St Oakland, MD 21550 Approximate Interval Between Onest and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Malia **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After this completely filled in hour. 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

30. Name and address of

31. Date filed (Month, Day,

Year)

29b. Signatur and title of certifier

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records.

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

oakland, Md 21550

11-04035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rancis	IVIAIIII		1- For State	e of Maryland i		rificate of		u Mentai r		2011 g. No.	10030
	Physici	an/	Registrar  1. Decedent's Name (First, Middle,La	-					2. Date of Death Month	n Dav Year	3. Time of Death 0806 hrs
rearca	I Exam	mer	Francis  4a. Facility Name (if not institution, gi	Aloysius ve street and number)	Manı		b. City, Town, or	Location of Deal	May 30, 20	4c. County of Dea	
			Atlantic General Hospital				Berlin			Wicomico	
	uneral		5. Social Security Number 6. 8		e (In yrs. las	st birthday)	If Under 1 Year Months Days	<del></del>	n.	n(MM/DD/YYYY) 9. B Fore	ign
	irector			<u>Х</u> м 2∏F	61	Yrs.			06-05	-1949 <sup>c</sup>	ountry) Wash., DC
	any		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Locati	on				10d. Inside City Limits
	Maryland 28a-f show d at once.	ō	MD Calve	rt			Chesa	apeake B			1 X Yes 2 No
;	or 28a-	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	with the Maryland ns 23a or 28a-f sho be notified at once.	al D	3917 14th Stree	t 12. Was Decedent	Ever in U.S	. I 13. Wa	20732 s Decedent of His		Specify Yes or No-	USA 14. Race - Ame	rican Indian, Black,
•	r item	Funeral	1 Never Married 2 X Marrie	d Armed Forces?			es, specify Cuban			White, etc.	
	after d	by F		d If Yes, Give Year or Dates:			Yes 2 No			Specify: Wh	
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212	uld be fil Mental I marked c event, i	To Be	Francis Aloysi 19a. Informant's Name/Relationship (			19b. Mailing	Address (Stree	Ver et and Number or		Williams  Der, City or Town, Stat	e, Zip Code)
QW	2 shouth and 27 is n		Elizabeth A. Man				•			Beach, MI	
<b>2</b>	ges I and 2 s of Health au If item 27 ther traums		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from Sta		lace of Dispos ematory or oth	ition (Name of cer ner place)	metery,	Date	20c. Location - City of	r Town, State
Baltimore,	. Page ment c tant: or oth		4 Donation 5 Other Specif	y:		ropolit	tan Crem	atory 06	5-01-11	Alexandri	
Ball	permit. Pages I a Department of He Important: If its injury or other t		21. Signature of Funeral Service Lice	nsee						eral Home, ngs, MD 2	
	ysician		23a. Part I. Enter the disease, or com		the death. I	Do not enter th	ne mode of dying,	such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
	decical aminer	0.3	failure. List only one cause on e Immediate Cause (Final disease	Atherosc1			iovascul	ar Disea	ise		Death
red .			or condition resulting in death)	Due to (or as a conse	equence of)	î.					
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928	titicate ing phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne of pregna		tal death 3	Ectopic pregr	nancy	23d. Date of delive Month	ry Day Year
Box 68760,	leath certificate e attending phy for use as the	Physician/N	1 Yes 2 No 9 Unknow	4 Pregnant at	time of dea	th 5 Oti	ner (Specify)				
G .	t the de by the ached f		Part II. Other significant conditions		but not res	sulting in the u	nderlying cause g	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
, P.O.	signed be deta	d by			_				1 Yes	2 <b>✓</b> No 3 Pro	obably 4 Unknown
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<u> </u>	ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	- 2 - 2 - 2	ER/Outpatient		of Death (Check	conly one)	Residence 6 Othe	
of Vital	g Physion Rer this Reral dir	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a Date of Iniu	ry I	28b. Time of Ir		ry at Work?	-	ow injury occurred	51.
<u>6</u>	tending sath. or: Aj the fur	ation	1 X Natural 5 Pending 2 Accident Investiga	(Month, Day,Y	ear)		1 🗆 🗅	res 2 No			
Division	or Att after de Direct I in by	Certification:	3 Suicide 6 Could no	t be 28e. Place of In	jury - At hor	me, farm, stree	et, factory, office b	ouilding, etc.	28f. Location (St or Town, Sta		ural Route Number, City
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	To wi	Me	29b. Signature and title of certifier	and manner stated.			29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
			シーでし				O.C.I	M.E.		May 31, 2011	
lew	1		30. Name and address of person who Donna M. Vincenti, MD	Assistant Medic			W. Baltimore	Street. Balti	more, MD 212	223	
KW	o\ S	tate	31. Date filed (Month_Day Year)	32. Registra		е,					
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,.e	Medic	al	Raymond										N	1ay 19,			07:25 PM <sup>M</sup>
4.1	Examin	er	4a. Facility Name (if Frostburg	Village Nu	rsing (	Care Cente					Frostbu	rg		Al	County of llegany	r	
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/lar	d be i	욘	Raymond	R. Miller	Sr.						Doroth	othy Weisenmiller					
lan.	of and 2 should be file of Health and Mental F fitem 27 is marked of rother traumatic ever		19a. Informant's Na		nip <i>(Type, F</i>			19b. Mailir	ng Addre	ss (Street	and Number o	or Rural F	oute Number	_		_	
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Baltimore, Maryland 21215-0036	permit. Page 1 a Department of I Important: If ite any injury or ot		20a. Method of Disp 1 📕 Burial 2 [ 4 🗌 Donation	Cremation		noval from State	,   0	Place of Dispo cemetery, crer rostburg 1	natory of	other place		May :	e 24, 2011	Frost	cation - Ci <b>burg</b>		wn, State aryland
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on of	Ter Ter		27. Manner of Death  1 Natural 2 Accident	5 Pendir Investi	g	28a. Date of inji (Month, Da	ury ny, Year)	28b. Time of injury	f M	28c. Injur work 1 🗔		- 1	d. Describe h	ow injury	occurred		
.≥	Direction of	d Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		28e. Place of Inj building, et			eet, facto	ory, office		28	f. Location (S City or Tow		Number o	or Rural	Route Number,
	he Hospital in 24 hours in he Funeral I pleted filled	Medical	(Check 2	Medical E	xaminer:	n: To the best o On the basis of actioner: To the	examinatio	n and/or inves	tigation,	n my opinie	on, death occu	urred at th	e time, date a	nd place, a	and due to	the cau	use(s) and manner stated.
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Ų.	6		30. Name and addre		who comp		leath (Item	23a) (Type 1		<i>y</i> = 0	1-1			11117		<u> </u>	
6	Ders.		Harjit			925 Bis	hop 1	Walsh 1		, Cum	nberlar	nd, M	ID				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ ROBERT NEWTON MORELAND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 8. Date of Birth (Month, Day, Year) 01/14/1919 5. Social Security Number 7. Age (*In yrs. last birthday*, 92 yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) est <u>Virginia</u> Hours Min. 1 X M 2 □ F Director 220-10-8596 West Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director WV1 ☐ Yes 2 🔀 No Mineral Ridgeley 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 26753 U.S.A. Old Furnace Road hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Master Plumber Plumbing 198 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleveland Moreland Anna Pearl Culp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Miller / Daughter Rt. 1, Box 72, Burlington, WV Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Abe Cemetery 05/22/2011 Ridgeley, WV 26753 22. Name and Address of Facility Upchurch Funeral Home, P.A 202 Greene Street, Cumberland, MD 21502 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician hemscler disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Pregnant at time of death Month Year Day Yes 2 No 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of Jas autopsy page death? certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗆 No Other: 1 Yes 잍 1 Dispatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Air completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 23,201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 924 Seton Drive, Cumberland, MD Vik Poonai, M.D. 21502

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Veal 0335 PAMELA JEAN McKENZIE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center umber and Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 - M 2 V Hours 08/21/1947 Country) 63 Director 219-46-1815 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits be notified at Director 1 Yes 2 No **Allegany** MD Cumberland 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral the Medical Examiner must 13802 Cardinal Drive, S.E. 21502 U.S.A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 M Married ☐ Yes 2 🕅 No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced White Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Orthodontics 12 Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert William Thom Eunice Ellen Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 13802 Cardinal Dr., S.E., Cumberland, MD Kenard McKenzie / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕵 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) injury or 05/27/2011 4 Donation 5 Other (Specify) Eckhart Cemetery Eckhart, MD 22. Name and Address of Facility Upchurch Funeral Home, P.A. 21. Signature of Funeral Servi 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final athensel ont Cardingsolan Physician disease or condition uran Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No jo Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this . Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at After (Month, Day, Year) 1 Natural 5  $\square$  Pending work 1 ☐ Yes 2 ☐ No hours after death. Ineral Director: A 2 Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 [] 3 [] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vik Poonai, M.D. - 924 Seton Drive, Cumberland, MD 21502

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2021 Barry I. Maizel 2011 Mau Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 X M 2 □ F Months Days 212-66-8319 Washington. DC 59 Yrs March Director Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Matural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits **Funeral Director** Rockville Maryland 1 Yes 2 X No Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 12312 Village Square Terrace, #102 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 🛛 Yes 2 🗆 No Specify: Argentinian Specify 3 Widowed 4 Divorced Completed Caucasian Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Contractor Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ည Rose Burak Louis Maizel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12312 Village Sqaure Terrace, #102, Rockville, MD20852 Leslie Maizel - Wife Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State Judean Mem. Grdns. 05/20/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Europeal Service Licer 10/29411800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it un, leading to immediate cause. Enter Underlying Examine Due to (or se a con esquence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician of for use as the burial. Physician/Medical  $M\alpha i \mathcal{L}el$   $\beta \alpha rry 5.18.11$  2 Division of Vital Records, P.O. Box 68760 Barry 5.18.11 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 🗌 Yes 2 🔀 No Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 X No 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 X Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31027 May 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 O'Brien, M.D., 31. Date filed (Month, Day, Year) State MAY 20 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03940 State of Maryland / Department of Health and Mental Hygiene Bruce Roger Macneil, II 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 26, 2011 1849 hrs **Medical Examiner** Bruce Roger MacNeil, 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Silver Spring 1110 Fidler Lane # 606 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 5 Social Security Number 6. Sex **Funeral** Foreign Country) RI Months Days Hours Director 037-42-0037 1 X M 38 Oct. 24, 1972 2 F Usual Residence of Decedent 10d. Inside City Limits 103 10c. City, Town or Location 1 Yes 2 No Silver Spring Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", nr items 23a or 28a-f shon nr other traumatic event, the Medical Examiner must be notified at once. Montgomery Director 10g. Citizen of What Country? 10e Street and Number 1110 Fidler Lane 20910 USA Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1X Never Married 2 Married 1 Yes 2 X No Specify: White 1 Yes 2 No specify: If Yes, Give Year 3 Widowed 4 Divorced <u>≥</u> 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 5+ Accounting Consultant Accounting 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bruce R. MacNeil Johanna Ecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce R. MacNeil/Father Griffin Drive, Warwick, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department of Important: I injury or other 5/29/2011 Metropolitan Crematory Alexandria, VA 4 Donation 5 Other Specify 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 2090 21. Signature of Funeral Service Licens Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Martical Death a Hypertensive Cardiovascular Disease Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, pt.II, 27, per me, g916 6-24-11 sm the attending physician ed for use as the burial X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Month Day Year 3 Ectopic pregnancy Fetal death 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by t I be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Morbid Obesity Completed ficate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No 28d. Describe how injury occurred After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 X Natural J Director: / Pending 1 Yes 2 No 24 hours after death. 2 \_\_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 27, 2011 OCME 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

TUN 0 1 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DEAN W. McCABE 3:40 PM 14 2011 May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BERLIN NURSING & REHAB CENTER BERLIN WORCESTER 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 💢 M 2 🗆 I Months Month, Day, Year, JULY 17. 1 Country)
DELAWARE Director 222-18-0241 78 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 34 WEST CHURCH STREET 19975 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OWNER/OPERATOR 12 SHOE STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHESTER Α. Mc CABE IDA HUDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. FAY McCABE/WIFE P.O. BOX 292, SELBYVILLE, DE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) BISHOPVILLE CEMETERY 5/18/11 BISHOPVILLE 21. Signature of Fymeral Service Licen 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 Part 1. Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on and line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eno Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical il or Attending Physician; The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performe 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical-Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) R 135131 May 16, 2011

GNA

State Registrar Healthway Dr.,

Berlin.

who completed cause of death (Item 23a) (Type, Print)

32) Registrar's Signature

Savage. 19 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Pleas	State of M		nd / Dep	artme		th and I	Mental Hyg	iene	e. 1 18105
Physicia		Registrar  1. Decedent's Name  Robert		ast) Nokes Sr.			timoat	.0 01 2000		2. Date of Death		3. Time of Death 4:37 P M
Medic Examin		4a. Facility Name (if	not institution, gi	ve street and number)			4b. City	, Town, or Locat		·	4c. County of D	eath
Funeral Director		4 Virgin: 5. Social Security No. 216–38–0	umber 6. 860	Sex 1 <b>X</b> M 2 □ F		last birthday) 69 Yrs.	If Unde Months		nder 24 Hrs.	8. Date of Birth 10/22/1	9.	Arunde1 Birthplace (State or Foreign Country) MD
Aaryland 8a-f show tified at	Director	Usual Residence of 10a. State MD	10b. County Anne Ar	unde1	10c. Cit	ty, Town or Lo	cation Sewat	er				10d. Inside City Limits 1 ☐ Yes ※※ No
n with the A is 23a or 2 nust be no	Funeral Di	10e. Street and Num					10f. Z	p Code 21037		1	0g. Citizen of What USA	Country?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire X7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11, Marital Status 1  Never Marr 3  Widowed	ied 2 ☐ Married	12. Was Decedent Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates.			Was Dece If Yes, spe 1  Yes	cify Cuban, Mex	cican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, thite, etc. White
vithin 72 hou iene. ir than "natu the Medica	Completed	(Spe Elementary/Seco	15. Decedent's cify only highest onday (0-12)	Education grade completed) College (1-4 or	5+)	(Give life. D	kind of wo	ual Occupation ork done during i e retired) [echanic		sing	16b. Kind of Busine	
ld be filed v Mental Hyg arked othe atic event,	To Be	17. Father's Name (						18. N		ne (First, Middle, M a Green	laiden Surname)	
nd 2 shou saith and n 27 is m er traum		19a. Informant's Na	·				_			al Route Number,	City or Town, State, 21409	Zip Code)
Page 1 arment of Hisant: If ite			Cremation 3	☐ Removal from State		Place of Disponentery, creation of the Olive	natory or	other place)		7/2011 E	20c. Location - City Trederick	, MD
permit. Depart Import any inj	Mt. Olivet Cemetery   5/17/2011   Frederick,  21. Signature of Funeral Sept@eltgensee   22. Name and Address of Facility   Hardesty Funeral Hor   12 Ridgely Ave. Annapolis, MD 21401											
Physician/ Medical		23a. Part 1. Enter t shock, or hear Immediate Cause ( disease or condition resulting in death)	rt failure. List only Final	mplications that cause one cause on each lin  a. Due to (or as	e. O L <i>W</i>	clial		of for I		or respiratory arres	st,	Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list co if any, leading to im cause. Enter Under	nmediate rlying	b. Due to (or as	a conseq	uence of):						
oe executer cian and ourial-trans	cal Examiner	Cause (Disease or that initiated events resulting in death) I	S	c. Due to (or as	a conseq	uence of):					,	
rtificate b ing physi e as the b		IF FEMALE:		d								
To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent in the past 12 r 1  Yes 2 9  Unknown	months?	23c. If yes, outcome  1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	aldeath 3	Ectopic Other (s	pregnancy pecify)			23d. Date of Month	delivery Day Year
luires that the signed by all the deta	۾			contributing to death t		sulting in the u	underlying	cause given in F	Part I.			to the cause of death?
The law rec ate has bee page 2 sho	Completed									24a. Was an autops perform	prior death	autopsy findings available to completion of cause of ? Yes 2 No
/sician: s certific director,		25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:	ient 2 🗆	ER/Outpatie	at 3 🗆 🗈	26. Place of Other:	,	k only one)	nce 6 Other (St	periful
ending Physath. Pr. After thi	Certificate: 1	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigati	28a. Date of inju (Month, Da	ıry	28b. Time of injury		28c. Injury at work?		28d. Describe hov		acciny)
ntal or Attural or Attural or Attural Directo		3 ∐ Suicide 4 ☐ Homicide	6 ∐ Could not determine	d 28e. Place of Inj building, et	c. (Specify	/)				City or Town,	State)	Rural Route Number,
thin 24 ho thin 24 ho the Fune	Medical	(Check 2	☐ Medical Exa	nysician: To the best of miner: On the basis of eurse Practioner: To the	examinatio	n and/or inves	tigation, in death occu	my opinion, deat irred at the time,	th occurred a date and pla	t the time, date and ce, and due to the o	i place, and due to the cause(s) and manner	ne cause(s) and manner stated. as stated.
2 % <b>2</b> 0		1	(1)	2,	W-			D 566	58		MAY 13,	2011
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NICKERSON, ROMALD JOHN

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			For State Registrar	State of M	arylan	-	artmei <i>rtificat</i>			Mental Hy	/giene Reg. N	2011	18106
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	Examin		4a. Facility Name (if not institution MEMORIAL	give street and number)				ASTO	Location of Death	h	4	C. County of Deat	
	Funeral Director		5. Social Security Number 042-30-4336	6. Sex 1 X M 2 G F	e (In yrs. la 72	st birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year I, I	9. Bir 9. MAT	thplace (State or Foreign untry) L
	aryland a-f show fied at	Director	Usual Residence of Decedent           10a. State         10b. County           MARYLAND         DORCH	FCTFD		, Town or Lo	cation						10d. Inside City Limits 1 □ Yes 2 🛛 No
	ith the Ma 3a or 28: t be noti		10e. Street and Number		1101	KLOCK	10f. Zi	p Code			10g. C	itizen of What Co	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	3925 WILLEY RO  11. Marital Status  1  Never Married 2 Mar  3  Widowed 4 Divorced	12. Was Decedent B		- 1			spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	USA  14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	hin 72 hour ne. than "natur e Medical	Completed	(Specify only higher Elementary/Seconday (0-12)	nt's Education est grade completed)  College (1-4 or 5	+)			ork done c e retired)	during most of wor	rking	1	Kind of Business	·
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Ma	12 shor		19a. Informant's Name/Relations  CHARLOTTE NICKE			1		•	and Number or Ru ROAD, HUF				
more,	Page 1 and nent of Hea ant: If item iry or othe	(s = 5)	20a. Method of Disposition  1	3 ☐ Removal from State	CE	lace of Dispo emetery, crer	osition (Na matory or	me of other plac	:e)	Date 3/2011	20c. l	ocation - City or	Town, State
Balti	permit. Departr Imports any injt		21. Signature of Juneral Service	cense	ler		ELLEI 06 M	rd Addin AIN S	ERAL HOME	ME, P. O EAST NEW	. BO MAF	X 207 KET MD	21631
21. Signature of Juneral Service Ocenses  22. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  23. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  24. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book, or heart failure. List only one caused each line.  25. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  26. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  27. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  28. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  29. Name and Address of Scility HOME, P. O. BOX 207 106 MAIN STREET, EAST NEW MARKET MI  20. Description of Science of Scie												Approximate Interval Between Onset and Death	
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Box	he death or y the atter iched for u	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1  Live Birth 4  Pregnant a 9  Unknown			☐ Ectopic☐ Other (s		y 			Month	Day Year
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Division of Vital Records, P.O. Box 68760	The law requested has been page 2 shou	Completed	Dysk	lipiden	nè					24a. Was auto perf 1  Yes	opsy ormed?	prior to death?	topsy findings available completion of cause of
/ital	sician: certific irector,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	D	PER/Outpatie	0 D E	Loui	ace of Death (Che			0 0 0 0 0 0	M. A.
on of \	nding Phy ath. r: After this e funeral d		27. Manner of Death  1 🖎 Natural 5 🗌 Pendir 2 🔲 Accident Investi	28a. Date of inju (Month, Da	ry	28b. Time of injury		28c. Injun work	/ at	28d. Describe		6 Other (Spec ry occurred	пу)
Division	ital or Atterns after degral Director	al Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place of Injurbuilding, etc	. (Specify)	)				City or To	wn, State	e)	ral Route Number,
	he Hosp in 24 hou he Funei pleted fil	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of e Nurse Practioner: To the	xamination	and/or inves	stigation, in	my opinio	on, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated.
	To t		29b. Signature and title of certified	, MD		29c. License number 29						ate signed (Month	n, Day, Year)
Oy	50		30. Name and address of person MAHBUBA	AULTER	, ,	203	BY/	en:	STREE	T, CAH	YBA	CIPGE	,MD-21613
	Stat Registra	e ar	31. Date filed (Month, Day, Year) MAY 20	2011 32 Registra	ar's Signat	4. 6	ak	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month S Day Physician/ Baig 2011 М Medical stitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death la. Facility Name (if not i **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER <u>ANNAPOLIS</u> Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1<u>935</u> Months Davs Hours NOV. 26, 1 X M 2 - F 75 WASHINGTON 519-36-4463 **Director** Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo QUEEN ANNE'S MARYLAND CHESTER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral **7B QUEEN VICTORIA WAY** UNITED STATES 21619 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status "natural", or ite ed Force 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. WHITE 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) th and Mental Hygiene.

7 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE 12 RISK MANAGER 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **NEAL DENMAN NELSON** KATHERINE PENCE t. Page 1 and 2 should be thent of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 323, CHESTER, MARYLAND, MARGARET NELSON/ WIFE 21619 other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION MAY DI'S. Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State CENTER STEVENSVILLE, MARYLAND 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses FENDOWS Addred FENDEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 00 disease or condition Medical resulting in death) Examiner ilog 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to ( as a conseq Sent the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical 00/48 229 or Attending Physician: The law requires that the death certificate be Box 68760 use as 1 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death the s signed by the detach€ P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) funeral 27. Man of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) 05-16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1A4300B SYEI 31. Date filed (Month, Day, Year) egistrar's Signature State 7 2011 MAY 1 Registrar

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		For State	State of Mar	yland /				and M	ental Hy	gien	e		
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Funeral	н	Allegany Health  5. Social Security Number   6. Se		Kehab . In yrs. last bi		If Under 1 Year	erla:		8. Date of Birt	h		egan Birthplac	ny ce (State or Foreign
Director		452–46–4040 1 Usual Residence of Decedent	□м 2 🗓 ғ 🧻 7 7		Yrs.	Months Days	Hours	Min.	11/29/	19 -	3 Te	Country) (as	
aryland a-f shov fied at	ector	10a, State 10b. County WV Hamps		I0c. City, Tov		sation Springfi	eld					10d.	. Inside City Limits 1 ☐ Yes 2 ☒No
th the Mi 3a or 28 t be noti	Funeral Director	10e. Street and Number HC 65 Box 311	1			10f. Zip Code	763			10g. C	Citizen of What (	 Country	?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Fune	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Eve Armed Forces?		13. V	Vas Decedent of H	lispanic Or	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ar Black, Wh		
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Page 1 arent of He nt: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemet	tery, crem	sition (Name of natory or other place and Cremat	ce)		ate /2011		Location - City umberla		
permit. F Departm Importa any inju once.		21. Signature of Funeral Service Ligens	·			Name and Addre				-			ome, P.A. 1502
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hysici nis cer I direc	일	examiner? 1 ☐ Yes 2- 🛱 No	Hospital: 1 ☐ Inpatient	t 2 = ER/0	Outpatien	t 3 🗆 DOA Oth	er: 4 🗗 N	lursing Hom	ne 5 🗆 Resid	lence	6 ☐ Other (Sp	ec <i>ify</i> )	
nding Pl ath. :: After the e funeral	cate:	27. Manner of Death  1.	28a. Date of injury (Month, Day, )		. Time of injury	28c. Injur work M 1 $\square$		_	3d. Describe h	ow inju	iry occurred		
l or Atte after dea Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (		farm, stre	et, factory, office		2	8f. Location (S City or Tow		nd Number or f e)	łural Ro	ute Number,
Hospita 24 hours Funeral sted fillec	Medical	(Check 2 Medical Exami	ician: To the best of my ner: On the basis of exam	mination and	or invest	igation, in my opinie	on, death o	occurred at t	he time, date a	nd plac	e, and due to th	e cause(	
Fo the vithin Somple	Ž	only one) 3 ☐ Certifying Nurs  29b. Signature and title of certifier	e Practioner: To the be	st of my kno	wledge, d	eath occurred at the 29c, License		e and place			(s) and manner ate signed (Mor		
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nds		30. Name and address of person why conil K. Gu				r <sup>int)</sup> Avenue,	, Cum	berla	nd, MD	2	1502		
State Registra	_	31. Date filed (Month, Day, Year)  MAY 1 6 2011	32. Registrar's	Signature	arks	1							
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a, 25, 26 per med cert Gylore All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Emil Paulson Month May 2011 7:59 Medical A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 111 Conestoga Court Boonsboro Washington Funeral Social Security Number If Under . Age (In vrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Month, Day Y 1 M 2 Days Months Hours Director 158-07-0591 89 Dec. Missouri 1921 Usual Residence of Decedent or 28a-f show 10a. State 10b. County death with the Maryland 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Md. Washington Boonsboro 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 111 Conestoga Court 21713 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married should be filed within 72 hours after tand Mental Hygiene.

is marked other than "natural", or Completed by 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify 3 V Widowed 4 Divorced 42 - 45Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Advertsing Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; if item 27 is marked oth any injury or other trainmair. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Emil Martin Paulson Ruth Curry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Paulson (Daughter) 111 Conestoga Ct. Bonnsboro, Md. 21713 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 27, 1 D Burial 2 Cremation 3 Removal from State Smithsburg Crematory Smithsburg, Md. 4 Donation 5 Other (Specify) 2011 Signature of Funeral Service Lie Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Oak. Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to ( / as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Day Year Yes been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ and Completed 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed 1 Yes 2 No Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes ပ 2 😾 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 20 d.S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Convey M.D. 45 Thomas Johnson Dr. Frederick, Md. 21701 31. Date filed (Month, Day, Year) 32. Registra s Signature State JUN 0 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5/14/2011 **Physician** 1157 M Nellie Ruth Priddy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Severna Park Heartlands Asst. Living If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 1/27/1913 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 □ M 2**XX** 405-20-2881 98 KY Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 □Yes XX No Director MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA 1213 Destiny Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2€ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White 1 ☐Yes ¾XNo þ Specify: 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Beautician Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Dixon Emma McDowell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerry Carlisle Son In Law 1213 Destiny Circle Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/17/2011 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P. A. Annapolis, MD 21401 130 J 12 Ridgely Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final rear disease or condition resulting in death) -vanc Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Completed 2 Be Medical Certification: To 2

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760 attending physician ō signed by the Division of Vital Records,

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show

death with the Maryland

within 72 hours after

Health and Mental Hygiene.

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainmasts.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

has page 2 certificate n 24 hours after death.

The Funeral Director: Appletely filled in by the fi

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							24a. Was an autopsy performed? 1 □ Yes 2 ┗ N	prior to death?	topsy findings available completion of cause of
25. Was case referred to medic examiner?	al				26.	Place of Deat	h (Check only one)		Assisted
1 Yes 2 No	Hospital	i: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 □ D	OA Other: 4	□ Nursing Ho	ome 5 Residence	6 Other (Spec	city) living
Z L Accident	ing tigation	. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes		28d. Describe how inju	ury occurred	
3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide detei	d not be mined 28e.	Place of Injury - At he building, etc. (Specif	ome, farm, street	, factor	y, office		28f. Location (Street a City or Town, Stat	and Number or Ru te)	ral Route Number,
	al Examiner: O						and due to the cause( red at the time, date ar		

completely

To the l within 2. To the l

State Registrar

and title of cert

29d. Date signed (Month, Day, rear)
5-16-2011

terans Hwy Millers ville MW 2/16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 12<sup>Day</sup> May Month 2011 ear Physician/ 2:40 A M Pabla Deva Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Casev House If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 February 12, 1957 Philippines Director 216-76-1568 Usual Residence of Deceder ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Marvland Montgomery Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20854 LISA 10600 Barn Wood Lane items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deceue... Armed Forces? Yes 2 1 No 11. Marital Status an "natural", or iter Medical Examiner ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: Asian 3 Widowed 4 Tolivorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) neath and Mental Hygiene.

w 27 is marked other than "
er traumatic even" than College (1-4 or 5+) Elementary/Seconday (0-12) Health and Beauty Cosmetologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Page 1 and 2 should be i nent of Health and Menta Kaushalya Devi Gursewa S. Pabla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 10600 Barn Wood Lane, Potomac, Maryland 20854 Anjali Julka-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 🔀 Cremation 3 D Removal from State 4 Donation 5 Other (Specify) Baltimore Washington Crem. May 13, 2011 Laurel, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 MO/237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Malignant neoplasm of the breast Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas perform page performed? Yes 2 X No 1 ☐ Yes 2 ☐ No this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗓 Other (Specify) 2 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d Describe how injury occurred After 1 injury 5  $\square$  Pending 1 ☐ Yes 2 ☐ No hours after death neral Director: A filled in by the fi Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) D37142 May 12, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman, MD, 1355 Piccard Dr. #100, Rockville, Maryland 20855 Date filed (Month, Day State Back Registrar

			Please Type or Print II  State of Maryl				_	_	10110	
		_	State Registrar	Cer	tificate of E	Death		g. No-	18112	
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last) Alice Lowe Peters				2. Date of Death May	18 <sup>Pay</sup> 20 Year	3: 54 p M	
	Examin	er	4a. Facility Name (if not institution, give street and number) 5742 Ross Neck Road			Location of Death		4c. County of Death Dorch	ester	
	Funeral Director		217-10-8944 1 M 2 🔀 F 93	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth OCL • 11	9. Birth Cour	place (State or Foreign <sup>htry)</sup> Maryland	
	laryland 3a-f show iffied at	1 h	Usual Residence of Decedent         10a. State         10b. County         10c.           MD         Dorchester	. City, Town or Lo		nmbridge			10d. Inside City Limits 1 □ Yes 2 🏿 No	
3	with the Ns 23a or 24	Funeral Director	10e. Street and Number 5615 Ross Neck Road		10f. Zip Code	.613	10	10g. Citizen of What Country? USA		
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rigury or other traumatic event, the Medical Examiner must be notified at once.	व	11. Marital Status  1 □ Never Married 2 □ Married  3 □ XWidowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ X No If Yes, Give Year or Dates.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh		
215-0	י 72 hou an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	16b. Kind of Business In						
212	withir giene yer th:		6	own hom	e					
Baltimore, Maryland 21215-0036	should be filed n and Mental Hy 7 is marked off raumatic even	To Be	17. Father's Name (First, Middle, Last)  Isaac Craig Lowe			18. Mother's Name	e (First, Middle, M. e Willey	aiden Surname)		
, Mar	nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Type, Print) Alice A. Ofano daughter	5742	Ross Nec	k Road, (	Cambridge		3	
imore	Page 1 a ment of H ant: If ite ury or oth		1 X Rurial 2 Cramation 3 Removal from State	ast New	matory or other place Market Ce	em. 5/21	l/11	20c. Location - City or T East New M	arket, MD	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home F 700 Locust St., Cambridge, MD 21613							
~ F	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the caused shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition for the condition of the condition for			_		st,	Approximate Interval Between Onset and Death	
S. Comment	Examiner	ner	Sequentially list conditions, b. Due to (or as a considerable list of the conditions).							
	be executed sician and burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  C.  Due to (or as a con-	sequence of);						
3760	ficate b g physic as the b	Medic	d							
. Box 6876(	The law requires that the death certificate b ate has been signed by the attending physicage 2 should be detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of deliver Month	very Day Year	
s, P.O	w requires that the dea s been signed by the a ! should be detached f		Part II. Other significant conditions contributing to death but no hypertension	t resulting in the t	underlying cause gi	ven in Part I.		acco use contribute to to		
Division of Vital Records, P.O.	<b>sician</b> : The law requ : certificate has beer irector, page 2 shou	Completed by					24a. Was an autops perforn	y prior to conned? death?	opsy findings available ompletion of cause of	
alF	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?			lace of Death (Checi				
ξ	Physic this ce al dire	은	I IMOSDITAL:	2 ER/Outpatie	-	4 ☐ Nursing Ho		nce 6 X Other (Specif	daughters home	
o uo	ending l eath. or: After the funer	Certificate:	1 Natural 5 Pending (Month, Day, Yea 2 Accident Investigation	injury	M 1 L	y at ⟨?   Yes 2 □ No	28d. Describe ho			
Divisi	tal or Att rs after de al Directo ed in by t		4 Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, str ecify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or Rura State)	al Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the best of my king only one) 3 ☐ Certifying Nurse Practioner: To the best of	nation and/or inves	stigation, in my opini death occurred at th	on, death occurred a ne time, date and plac	t the time, date and ce, and due to the	d place, and due to the co cause(s) and manner as s	ause(s) and manner stated.	
	North Con		29b. Signature and title of certifier  Parkers W		29c. Licens	e number 20 5 9 9 7	3	9d. Date signed (Month, 5/20/11	Day, Year)	
	り		30. Name and address of person who completed cause of death	(Item 23a) (Type, U Bran	print)	ambri	dge 1	5/20/11 10		
	Sta	te	31. Date filed (Month, Day Year) 22. Registrar's S	ignature 50	del					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>011</u> Month Mav Physician/ Lee Parsons Wilda 23 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Allegany Health Nursing & Rehab Ctr. If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number **Funeral** 197667 1922 Mary Land 88 Director 217-18-4146 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and "naturalr", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified and injury or other traumatic event, the Medical Examinar must be notified and injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 517 Eastern Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black White etc. 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Crabtree Steckman Pearl Adell Melvin Leroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Louisiana Avenue, Cumberland, MD Barbara A. Appel / Daughter Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State MD Vet Cem @ Rocky Gap 05/26/2011 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signa of Funeral Service 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner sque tially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L recarded
Pregnant at time of death Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician; I within 24 hours fer death.

To the Funeral Director After this certific: completed filled in by the funeral director, I Be 25. Was case referred to edical 26. Place of Death (Check only one) examiner? Other: 2 No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2  $\square$  No 2 Accident Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Cepartying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 3 mll

Registrar
DHMH 17 Rev 7/2009

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Paniczko 7:16  $p^{\mathsf{M}}$ 2011 Helen Theresa 14 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Silver Spring 15100 Glade Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birune. Country) PA 1 M 2 DXF Months Days Hours Min April 26, 86 579-42-1262 1925 Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d, Inside City Limits notified at Director 1 Yes 2 No Silver Spring MD Montgomery 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a USA 20906 15100 Glade Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Black, White, etc Ь þ 1 X Never Married 2 Married Yes 2X No Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. Department of Interior life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Secretarial Administrator Federal Government 12 other traumatic event, Be filed permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Adela Veronica Mrozowska ည Adam Alexander Paniczko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1080 Clippers Way, Tarpon Springs, FL 34689 Margaret Wilbur/Niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 21, May Olivet Cemetery  $\frac{2011}{2}$ 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. In the C May 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death signed by the a Id be detached f 2X X No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available has le 2 autopsy performed? Yes 2 🔀 No prior to completion of cause of death? page certificate 1 Yes 2 No Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 XNo Other: 1 Yes ၉ this ( 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 👣 artif 🖍 ing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title 29c, License number 29d. Date signed (Month, Day, Year) 10 May 16, 2011 D35635 completed cause of death (Item 23a) (Type, Print)
D 18111 Prince Philip Drive, Olney, MD 20832 Joseph Kaplan, MD 31. Date filed (Month, Day, Year, Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

MAY 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 08, 2011 02:40 PM M William R. Price Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany LaVale 5 Richard Way Social Security Number If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Months Days Hours Min. (Month Day Maryland Director 87 February 07, 1924 219-14-5330 Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No LaVale Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Richard Way Funeral U.S.A. 21502- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW. 1 Yes 2 No Specify Specify: "natural" Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Grocery Store** Assistant Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Margaret K. Shannon Robertdeau Annan Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502-Maryland **Doris Price** 5 Richard Way LaVale 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State May 11, 2011 Frostburg Maryland Frostburg Memorial Park 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Dart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALLIHEIMER' Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔑 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760 **Division of Vital** To the Hospital or Attending.
within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun

၉

Certificate:

Medical

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

29a. Certifier

5 Pending

10

Investigation 6 Could not be

determined

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg Donaldson

29c, License number 1) 42054

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Day, Year)

28f. Location (Street and Number or Rural Route Number,

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

28d. Describe how injury occurred

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

28a. Date of injury (Month, Day, Year)

912 Seton Drive, Cumberland, 21502

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 201 narles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Queen Stevensy i If Under 1 Year If Under 24 Hnnes Kohinson 8. Date of Birth (Month, Day, Birthplace (State or For Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 32-5355 6 Marylano Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mast be nutfilled at agnes. Once. 1 Yes 2 □ No Director Stevensville 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21666 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Black <u>გ</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction pervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stevensville, MD 21666 ames 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Grusonville 4/2011 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home, PA. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 510 Washington MD21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANCEIL 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner STAG Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2. No has funeral director, page 2 s 2 No certificate 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 1 Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deatle Funeral Director: completely filled in by the 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

3

State Registrar

egistrar MA

31. Date filed (Month, Day, Year)

204 Medical Center Rd. Grasonville MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wilkerson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ρM Robert Eugene Ridgley May 2011 9:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Villa N.H. Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min 1 🔀 M 2 🗆 F Hours 81 08/27/1929 Yrs Director 214-26-9967 Usual Residence of Decedent 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 9725 Riverside Circle 21042 United States tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 6 þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify: "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tractor Trailer Driver Commercial Trucking Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Department of Health and Ment.
Important: If item 27 is markent any injury or are. Osborne Ridgley Mildred Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9725 Riverside Circle Ellicott City, MD 21042 Robin Ridgley - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🗷 Other (Specify Entombment 05/24/2011 Crest Lawn Mem. Marriottsville, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 21. Si atu e of Funeral Service/Ligens/ 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ NJ disease or condition Medical resulting in death) or as a consequence of **Examiner** An Ki Num's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exam and Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 No the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe **Director:** After this certificate It in by the funeral director, page 2 No 1 Yes 2 No Yes Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending injury Accident 5 Pending work 1 Tes 2 🗌 No after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examine: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signarur 29d. Date signed (Month, Day, Year) Felenal A. to 100 CAnon 1/k MDZ1271 Jause of death (Item 23a) (Type, Print) 14 COMUND egistrar's Signaturg 31. Date filed (Mon State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

										lental Hyg		_	10110	
	1	For State Registrar				_		of Death			Reg. No.	UII	8118	
Physician		1. Decedent's Name (First, Midd Dorothy Eloi		sch						2. Date of Dea Month	th Day	$20\overset{\text{Year}}{1}$	3. Time of Death 11:15 p M	
Medica Examine		4a. Facility Name (if not institution				1		own, or Location	n of Death		4c.	County of Deat	h rett	
Funeral Director	- 1	Garrett County 5. Social Security Number 070-26-6962	6. Sex	7. /	Age (In yrs. la 80		If Under 1		er 24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birt	hplace (State or Foreign untry)	
		Usual Residence of Decedent  10a. State  10b. Count	<u></u>			y, Town or Lo	neation			11 1	8	930 NY	10d. Inside City Limits	
Marylan 28a-f sh atified a	recto		rrett			akland							1 ☐ Yes 2 📈 No	
with the 23a or 2	Funeral Director	10e. Street and Number 3701 Garrett H	ighway				10f. Zip Code 21550					zen of What Co USA	untry?	
min e	ا ۾	11. Marital Status  1 ☐ Never Married 2 ☐ Ma 3 🖼 Widowed 4 ☐ Divorce	arried 1	as Deceden med Forces Yes 2 Yes, Give ear or Dates	<b>X</b> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:					14. Race - American Indian, Black, White, etc. Specify: White		
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uld be fil I Mental narked natic ev	잍	Harold James Vibbard Arlene Jarvis Pope												
id 2 shor saith and n 27 is n er traun		19a. Informant's Name/Relationship (Type, Print) Henrietta Lyons, daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi 3701 Garrett Highway, Oakland, MD 2155										O Code)		
age 1 an ant of He it: If iten y or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Crematio 4 ☐ Donation 5 ☐ Other		val from Sta	to C	emetery, cre	osition (Name matory or oth	of Perplace) natory		Date / 2011		pation - City or		
permit. P. Departme Importar any injur.		21. Signature of Funeral Service		1doc	B	2	2. Name and	Address of Fac	ility Dar		Burdo	ock Fun	eral Home PA	
Physician/		23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complication only one cau	se on each I	On	h. Do not ent				r respiratory arro	est,		Approximate Interval Between Opset and Death	
be executed sician and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. — c. — d. —	Due to (or a	as a consequence as a c	MOA uence of):	rang	Hq	pers	trasi				
To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the templated filled in by the funeral director, page 2 should be detached for use as the templated for use as the templated for use as the templated for use and the following the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	Live Birt	ne of pregna h 2  Feta t at time of c	aldeath 3	☐ Ectopic pr ☐ Other (spe				2	3d. Date of de	livery Day Year	
res that the signed by different be detailed.		Part II. Other significant condi	tions contribu	ting to death	but not res	ulting in the	/ -	use given in Pa	ırt I.				the cause of death?	
The law requate has been page 2 shoul	Completed	Obe	ed of	y		,				24a. Was a autop perfor		prior to death?	topsy findings available completion of cause of	
sician; certifica irector, I	Be	25. Was case referred to medica examiner?  1  Yes 2 No	ll Hospit	al:				26. Place of Do		only one)				
ding Phys h. After this funeral di	sate: To	27. Manner of Death Natural 5 Pend	ding	Ba. Date of in		28b. Time of injury	of 280	c. Injury at work?		me 5 Resid			ify)	
I or Atten after deat Director: d in by the	Certificate:	3 ☐ Suicide 6 ☐ Coul	d not be mined		njury - At ho etc. <i>(Specify</i>		reet, factory,			28f. Location (S City or Town		Number or Ru	ral Route Number,	
e Hospita 124 hours e Funeral	Medical	(Check 2 L Medical	Examiner: O	n the basis o	f examination	n and/or inve	stigation, in m	y opinion, death	occurred at	d due to the cau the time, date ar e, and due to the	nd place,	and due to the	cau <b>s</b> e(s) and manner stated	
To th within To th comp	2	29b. Signature and title of certifi						License number	r		29d. Date	e signed (Month		
'	4	30. Name and address of perso						th St,	Suite	e II, Oa			21550	
State Registra		31. Date filed (Month, Day, Year)												

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 10:00 PM Rita Mae Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2424 Blue Goose Rd. Friendsville Garrett Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. June 14, 1952 Pennsylvania Director 218-60-0546 58 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Garrett Friendsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2424 Blue Goose Rd. 21531 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Ş 1 Never Married 2 K Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working Garrett County Board life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Education 1 and 2 should be filed within the Health and Mental Hygiens item 27 is marked other the Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Woodrow Friend Alfreda Hanft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is William F. Robinson/Husband 2424 Blue Goose Rd., Friendsville, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) John's Cemetery May 23, 2011 Accident, MD 21. Signature of Fylleral Service Co 22. Name and Address of Facility Newman Funeral Homes, P.A. · dus umas P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or infart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ ( Corcumonno disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): sician and burial-transit Exami that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery lo in the past 12 months? Day Year 1 Yes 2 No 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Physician: The law requires cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 15333 : kus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th St., Oakland, MD Thomas Johnson, Day, Year) 2 4 2011 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2:15 PM DDies Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 25mn If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months Hours 0 Director 11/16/1947 Marvland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔽 No Cumberland MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA Funeral 15820 McMullen Highway, death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Maximone. College (1-4 or 5+) Elementary/Seconday (0-12) Private School Teacher 12 Be 18. Mother's Name (First, Middle, Malden Surname)
Bessie Mildred 17 Father's Name (First, Middle, Last) Johnson Rosier ည Walter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HC. 69 Box 42. Brandvwine, WV 26802 HC 69 Box 42, Brandywine, WV Helen Troutman / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Pinto, MD Pinto Mennonite Cem. 05/23/2011 4 Donation 5 Other (Specify) re di Funeral Service Lio n 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) ue to ir as a consequence of) Examiner week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the a should be detached f 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita 1 Tyes Medical Certificate: To Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) DOA Manner of eath Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 001 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nRS

Registrar

State

32. Registrar's Signature

	ded #6, FD, 05		/11 Alle		ase Type or o. State o	<b>Print in</b> f Marylar								_	le.		
			<ul><li>State Registrar</li></ul>				Cei	tifica	te of L	Death			Reg. No	.201	Avenue A	18	121
	Physicia	an/	1. Decedent's Nam	e (First, Middl						_		2. Date of De Month		ayo o 4 4 <sup>Ye</sup> a	ar	3. Time of	
	Media	cal	Merritt		Alexan		Ridgel				Sr.	May	- 1	2011		4:42	<u> HW</u>
	Examir		14206	Winch	ester Road	WS				Location of the Location of th	n			Allega	any		
	Funeral Director		5. Social Security N  220-26- Usual Residence of	9869	6. Sex 1 <b>X</b> M 2 DE	7. Age (In yrs. i	ast birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Dec	30,	1931	Birthpla Country	MD	or Foreign
	aryland a-f show fied at	Director	10a. State	10b. County	llegany	10c. Cit	ty, Town or Lo	cation	town	-					100	d. Inside C	ty Limits
	th the Ma 3a or 28 t be noti		10e. Street and Nur	nber				10f. Z	ip Code	215			10g. C	itizen of What	: Countr		
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98	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	by	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>		rried Armed Fo	rces? 2 No				n, Mexican		cify Yes or No- Rican, etc.)		Black, W	/hite, et		
9	hours natura lical E	lete	ii:	15. Decede	ent's Education	iles.	16a. Dece	dent's Usi	ual Occup	ation			16b. l	L Kind of Busine			
21215	vithin 72 jiene. er than "r the Med	Completed	Elementary/Sec	, , ,	est grade completed) College (1	-4 or 5+)	life. D	O NOT us	se retired)	during most tracto		ng	cc	onstruct	tion	-	
and 2	be filed within ental Hygiene. ked other thar ic event, the M	To Be	17. Father's Name (		<sub>Last)</sub> Ridgeley					18. Mothe	er's Name	(First, Middle llen (Tw					
Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na		ship (Type, Print)	son	19b. Maili	ng Addres 32 At	ss (Street a	and Numbe Aveni	er or Rura J <b>e</b>	Route Numbe	er, City o	ester	, Zip Co V	<sup>de)</sup> 22	2601
Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to		20a. Method of Disp 1 X Burial 2 4 ☐ Denation	☐ Cremation	3 Removal from	State 20b. I	Place of Dispo cemetery, crer estlawn	sition (Na natory or Memo	me of other place orial G	ardens		<sub>oate</sub> 5/21/201	l	_ocation - City		n, State	MD
Baltii	permit. P Departm Importar any injur		21. Sonatur of Fu				22	2. Name a				ome, PA e: Cumbe	rland	MD 2150	N2		
				rt failure. List	r complications that conly one cause on ea	ch line.			de of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximaterval Bet Onset and	ween
	Physician/ Medical Examiner		disease or condition resulting in death)		a. Due to	or as a conseq		n C	000	777		Pula	1000 F	7 4.52		yes	5
	ed sit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	rlying	b. Due to (	or as a correct	ue roe oi):										
0	be executed sician and burial-transit	1 1	that initiated event resulting in death)	S	c. Due to (	or as a conseq	uence of):			-							
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be aw within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 🗆 Feta nant at time of	al death 3	Ectopic Other (s		Ç <b>y</b>				23d. Date of Month			Year
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Division of Vital Records,	aw requir as been s 2 should	Completed		70/00	fensing							24a. Was	an	24b. Were	autops	y findings	available
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Divis	ital or At urs after of ral Direct led in by		4 Homicide	deterr	ningd 28e. Place	of Injury - At hong, etc. (Specif)		eet, facto	ry, office			28f. Location ( City or To			Rural F	oute Numi	oer,
	he Hosp in 24 hou he Funer pleted fill	Medical	(Check 2	Medical	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of examinatio	n and/or inves	tigation, ir	my opinio	on, death of	curred at	the time, date	and plac	e, and due to t	the caus	e(s) and ma	anner stated.
	Viit viit		29b. Signature and	title of certifie				29	c. Licenso		44		29d. D.	ate signed (Me	onth, Da	ay, Year)	
	5		30. Name and addr	ess of person	who completed caus	e of death (Iten	n 23a) (Type, F	Print)					NAT	NIE	(21	)	
	∫1 ek√ Sta	te	JESUS 31. Date filed (Mont	h, Day, Year)	1.D. 4 BH	egistrar's Signa	ture	NKC		TK()	2114	IKO,	11/1	Salo	100	<b>J</b>	
	Registr	ar	14	AI II	2011	ua B	· Loon	A STORE OF THE PARTY OF THE PAR									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18,2011 Physician/ May 5:31a Paula Ramirez Ana Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Takoma Park Montgomery 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1071971952 El Salvador 1 □ M 2 🗙 F 58 225-57-4631 Director Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director MD Hyattsville 1 Yes 2 No Prince George 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe 20783 El Salvador Funeral 2214 Beech Wood Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. White Armed Forces 1 ☑ Yes 2 □ No El Salvadoran þ 1 X Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Self employed Import Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental F Department of Health and Menta Important: If item 27 is marked any injury or other ဂ္ unknown Maria Mariquita Ramirez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2214 Beech Wood Road Hyattsville, Md 20783 Ermelinda Ramirez/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Cemetery crematory of other place)
Cemeter 10 General 5/24/2011 La Union, 1 Burial 2 Cremation 3 Removal from State El Salvador 5 Other (Specify) 4 Donation 21. Signature of PHILIPADER TO ALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

Probable Pulmoning Enholosing Approximate Interval Between Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Heint Pisesse. **Examiner** vertensive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last ing physician are as the burial-t Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year for 5 Other (specify) Pregnant at time of death should be detached the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has t irector, page 2 s 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Manner of Death 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Box 68760 P.O. Records, **Division of Vital** s after death. within 24 hours after c

To the Funeral Direct

completed filled in by filled in by Hospital

Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 18,2011

and address of person who completed cause of death (Item 23a) (Type, Print)
mes K.Lightfoot MD 7600 Carroll Ave.Takoma Park, Md 20912

State Registrar

31. Date filed (Month, Day, Year)

MAY 20 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2, Date of Death Month Physician/ JAMES RITCHIE 5 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 ₹ M 2 □ F Hours **Director** 216-22-6145 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Allegany Rawlings 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 15409 Hawk Street 21557 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed 3 Widowed 4 Divorced WWII Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Kelly-Springfield Elementary/Seconday (0-12) College (1-4 or 5+) Tire Company Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Amelia Drew Anthony Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Lee Ritchie / Wife 15409 Hawk Street, Rawlings, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 05/21/2011 Biertown Cemetery Rawlings, mD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Upchurch Funeral HOme, P.A. 21502 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ 240 disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been shown that the death of the certificate be executed. signed by the attending physician and the detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 € Probably 4 ☐ Unknown cate has been signated by page 2 should by . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier SUDHEER SANIKOMMU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Letillaubrook Road, Comberland MD 21502

Registrar DHMH 17 Rev 7/2009 Sapikommy

T8 2011

12500 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	ate of Maryland		artment of tificate of		and Mer		ene 1. No. 20	Buttered and the second	18121
			Decedent's Name (First, Middle, Last)					2.	Date of Death	, NO. (	1 4	3. Time of Death
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7	Examin		4a. Facility Name (if not institution, give street a			4b. City, Town, o	or Location o	of Death		4c. County of Death		
			Frederick Memorial	Hospital		Frede	rick			Frederick		
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days			Date of Birth	aarl .		ace (State or Foreign
	Director		578-22-0477 1 TXM 2	□F 88	Yrs.	Months	riours	M:	arch 9,	1923	Wash	Mington,D.C.
	ow at	_	Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Loc	eation					10	Od. Inside City Limits
	arylar a-fsl	cto	Maryland Frederick		reder							1 X Yes 2 □ No
:	or 28	P.	10e. Street and Number			10f. Zip Code			100	10g. Citizen of What Country?		
	re filed within 72 hours after death with the Maryland tall Hygiene. A properties than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Funeral Director	809 Eden Court				1701		10,	USA		
	ems ems	ığı	11. Marital Status 12. Wa	s Decedent Ever in U.S	i. 13. V	Vas Decedent of I	Hispanic Orig	igin? (Specify	Yes or No-	14. Race	America	an Indian.
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7	d wit Hygie ther nt, th	Be C	17. Father's Name (First, Middle, Last)		1400		T 40 11 11					
ang	ental Hygiene. ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	일	William F. Sampse	11e			1	er's Name <i>(Fil</i> dys Sh	rst, Middle, Mai inlay	iden Sumame)		
Maryland 21215-0036	should be fill and Mental is marked ( aumatic eve		19a. Informant's Name/Relationship (Type, Prin		40E M-10-	- A	<u> </u>				4- 7:- 0	
	age 1 and 2 should be ant of Health and Ment it: If item 27 is marked y or other traumatic e		Joan Sampselle - wi	•	809	g Address <i>(Street</i> E <b>den Cou</b>	rt, F	rederi	ck, Mar	yland 2	2170	L
<u>ත</u> ු	f and f Hea item other		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of	-	Date	20	Oc. Location - C	ity or Tov	wn, State
ê .	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State Sta	emetery, crem utfer	Cremato	ry 5	5-20-20	1	ederick		
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Ligensee		22	. Name and Addre	ess of Facilit	ty Stai	iffer F	uneral	Home	
ñ	e a m e		Sharon Cance	le Cleu	e 16	21 Opos	sumtow					
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus	s that caused the death	n. Do not ente	r the mode of dyi	ng, such as	cardiac or res	spiratory arrest	,		Approximate
-P	nysician/	8 3	Immediate Cause (Final disease or condition		= W	40CARI	VIA	11160	METION	j	n	Interval Between Onset and De h
1	Medical		resulting in death)	Due to (or as a consequ	ence (f):	TUCKIN	, ,	INIP	1-1101		100	1014
	Examiner	_	Sequentially list conditions, b. —	ACI	10							
7	, .±	jie	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):							
4	and trans	Examiner	Cause (Disease or iinjury that initiated events c resulting in death) Last	Due to (or as a consequ	once of:						-	
_ 3	ceruncate be executed nding physician and use as the burial-transit	dical E	resulting in death) Last	oue to tor as a consequ	erice oi).							
20/	phys	edic	d									
80	ding se as	<u>×</u>	IF FEMALE: 23b. Was decedent pregnant 23c. If y	es, outcome of pregnar	ncy					22d Data	of dolivo	
. Box	atten	cial	in the past 12 months?	☐ Live Birth 2 ☐ Feta ☐ Pregnant at time of d	Ideath 3 ∟	Ectopic pregnar Other (specify) _	псу			23d. Date Mont		ry Day <b>Ye</b> ar
n a	y the	Physician/Me		Unknown		(, ),-						
P.O. Box	requires that the death certhics been signed by the attending p should be detached for use as t	by P	Part II. Other significant conditions contributi	-	ulting in the u	nderlying cause g	iven in Part	I.	23e. Did toba	cco use contrib	ute to the	e cause of death?
JS,	n sign		HEART F	PAILLIRE					1 🗌 Yes	2 🗆 No 3	Prob	ably 4 🗌 Unknown
Ö	w rec s bee	plet							24a. Was an			sy findings available npletion of cause of
မှီ င	ate ha	Completed							autopsy performe 1  Yes 2	ed? de	ath?	
	ntifica ctor, p	Be	25. Was case referred to medical examiner?			26. F	lace of Deat	th (Check on		E NO		
5	nysic his ce I dire	2	1 🗆 Yes 2 🗖 No Hospita	l: 1 Inpatient 2 🗆	ER/Outpatien	t 3 🗆 DOA Oti	ner: 4 🗆 Nu	ursing Home	5 Residence	ce 6 🗆 Other	(Specify)	
o i	ing r	ate:	27. Manner of Death  1 Natural  5 Pending	a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju wor	k?	1	. Describe how	injury occurred		
oi i	tor: A	iffic	2 Accident Investigation				Yes 2 🗆	_				
Division of Vital Records,	or An after of Direction by	Certificate:	4 Homicide determined 28e	<ul> <li>Place of Injury - At hor building, etc. (Specify)</li> </ul>		et, factory, office		28f.	Location (Stree City or Town, S	et an <i>d Number</i> State)	or Rural I	Route Number,
ב ב	spiral lours reral filled		29a. Certifier 1 Certifying Physician: T	o the best of my knowle	edge death o	ccured at the tim	e date and	place and di	le to the cause	(s) and manner	as stated	1
1	to the rospital or Authoring Prysician; the law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	(Check 2 Medical Examiner: On only one) 3 Certifying Nurse Pract	the basis of examination	and/or invest	igation, in my opin	ion, death oc	ccurred at the	time, date and	place, and due t	o the cau	se(s) and manner stated.
4	Within To the comp	-	29b. Signature and title of certifier			29c. Licens	se number			d. Date signed (		
			> Wille		MD.	1	264	199		5-1	5-	//
	$\sigma_{l}$		30. Name and address of person who complete	ed cause of death (Item	23a) (Type, P	rint)						
			Ronald E. Miller,  31. Date filed (Month, Day, Year)	M.D.	4 Culw	ell Driv	e, Mt	. Airy	, Maryl	and 2	1771	
	Stat Registra		NAY 19 2011	32. Registrar's Signat	A. A	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eugene Gerald Swartz 12:21 РМ May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country)
Kenosha Days Min 1 🖾 M 2 □ F Months 389-30-1365 77 Yrs. Director October Wisconsin Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director r 28a-f sl notified 1 X Yes 2 No Maryland Prince George's College Park 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 9008 Acredale Court 20740 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. KOREAN 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. 2 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Distributor Business Owner t. Page 1 and 2 should be filed with transt of Health and Mental Hygier rtant: If item 27 is marked other t njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ James Edwin Swartz Sylvia Louise Cappaletti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Mary Swartz / Wife 9008 Acredale Court, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Department of Important: If any injury or 5/29/2011 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Fhysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BRILLATION Sequentially list conditions, Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 2 No 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 1 NO Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 110 Other: 1 Tes မူ 1 Dempatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-5928 201

State Registrar

1041

ADVENTIST HOSP.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STATE WAS HIVE TON

TAKOMA PARK MD-20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last, Month Year **Physician** 05 11:40M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rrs. last bir hday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. pecialty Inivers more 5. Social Security Number 7. Age In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1₽M 2□ F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1. ☐Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or item any Injury or other traumatic events. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 20 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify ACK Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1)4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be mulh မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Well. 20b. Place of Disposition (Name of cemetery, prematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 201 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Sanic Dicenses 22. Name and Address of Facility 7000 MONT Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastat Canc /Medical Due to (or as a consequence of): Examiner nasar if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10050 auus mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZERA 10HANNES 601 S. Char 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 5 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sel Mail 201 0920 AM telestine. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Advantist Takoma Park HOS AHEL Montgomery Birth 1948 9. Birthplate (State or Foreign Day, Year) North Carolina If Under 24 Hrs 8. Date of Birth . Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F Hours Min. North Carolina Director 62 November Usual Residence of Decedent fshov 10b. County 10a. State 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 □ No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 United States 4005 - 14th Street, N. W. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: **Black** Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) NeighborsWorks America Customer Response Manager 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Mildred Leah Taylor Robert Lee Whitaker, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 - 14th Street, N.W.; Washington, D.C. 20011 Sonya Nicole Sellers (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 28,2011 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland National Harmony Memorial Park 22. Name and Address of Facility R. N. Horton Company Morticians, 21. Signature of Funeral Service Lice, Inc.;600 Kennedy Street, N.W.; Washington, D.C.2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician atheroscherotic Goronary Medical resulting in death) Due to (or as a consequence of): **Examiner** end Stage runa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): signed by the attending physician the detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 NGR/Outpatient 3 IDOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 1 Natural (Month, Day, Year) injury 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 Carroll Avenue Tokomu Park, MD Amber Marshall

DHMH 17 Rev 7/2009

Registrar

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05<sup>Month</sup> Physician/  $201^{\text{fea}}$ 5:10 26 ам James Kenneth Shaffer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cherry Hill Assisted Living LLC Accident Garrett Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 ■ M 2 □ F Hours 07 02 1923 Director 213-12-9812 87 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35 Dewey Roy Lane 21550 IISA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Completed by 1 Never Married 2 Married 1 Yes 2 X No 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: Specify: 3 

■ Widowed 4 

□ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) salesman bread 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Shaffer Mary DeWitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Jonna Frazee-daughter</u> <u> 2434 Herrington Manor Road, Oakland, MD 21550</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State Oakland Cemetery 5/28/2011 Oakland, MD 4 Donation 5 Other (Specify) 21. Signature funeral Service Licens 22. Name and Address of Facility David A. Burdock Funeral Home PA 21 N. 2nd St, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ho Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1/51 ☐ Yes 3 Probably 4 ☐ Unknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson, M.D., 311 North Fourth Street, Suite II, Oakland, MD 21550 Thomas G. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

29a. Certifier

29b. Signature and title of certifie

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1<sup>Day</sup> 20°11 0130 A M MAY THOMAS L. SMITH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
WORCESTER **Examiner** BERLIN ATLANTIC GENERAL HOSPITAL 9. Birthplace (State or Foreign NEWntrYORK Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday, **Funeral** 1 🛛 M 2 🗆 F Min. 4M917-D1913 Director 050-07-2441 93 Usual Residence of Decedent "natural", or items 23a or 28a-f shov dical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland Director 1 ☐ Yes 2ሺ No SUSSEX SELBYVILLE DELAWARE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S. 19975 3709 EAST STONEY RUN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 🗌 No WHITE 1 ☐ Yes 2 X No Specify: Year or Dates.41-45 Specify: 3 🗆 Widowed 4 🗆 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) TRADE ASSOCIATION DIRECTOR OF CREDIT Be 18. Mother's Name (First, Middle, Maiden Surname)
MILDRED EVELYN CROTER 17. Father's Name (First, Middle, Last) LEWIS COMBS SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3709 EAST STONEY RUN, SELBYVILLE, DE. 19975 HILARY L. SMITH/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ST. GEORGE'S CEMETERY 5-21-11 1 X Burial 2 Cremation 3 Removal from State FRANKFORD, DELAWARE 4 Donation 5 Other (Specify) 21. In nature of Inches Service Linensee MELSON" FONERAL HISERVICES, LTD 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hemmorphanic disease or condition resulting in death) + ht vacrania Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it g Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to thours after death. Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No of Vital Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number Do064120 and address of person who completed cause of death (Item 23a) (Type, Print) Aat 9733 Health way Drive Berlin Atif Zeeshan DH 10H 31. Date filed (Month, Day, Year)
MAY 2 0 32. Registrar's Signature State 2011 park Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Streett Glentis 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ailegany wmHS-Regional medical Center Cumber land If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** Social Security Number 7. Age (In vrs. last birthday) Country) PA Aud 10, 1 □<sub>X</sub>M 2 □ F Director 219-14-6922 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bedford Bedford 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 15522 USA 1106 Bedford Valley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: white 3 □ Widowed 4 □ Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PPG foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helen Oster Claude A. Streett 19a. Informant's Name/Relationship (Type, Print)
Glenda Ely 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 716 Lafayette Ave. Bedford PA 15522 daughte 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery crematory or other place) Union Cemtery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/18/201 PA Bedford 4 Donation 5 Other (Specify) 21. Signatur > Funeral Service Licenses 22. Name and Scarpeni Full eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year 1 Yes 2 No ed by the a detached f 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗶 No Yes 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☐ No 1 Npatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie (Type, Print) D0066/01 5/16/11
12500 Willow brook Rd mozil ess of person who completed cause of death (Item 23a) (Type, Print) CHEEMA State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hugh Caldwell Speir Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Western Maryland Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Days Min Months Hours Director December 10, 1927 Maryland 212-24-1564 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗖 No Frostburg Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Honeysuckle Lane Funeral U.S.A 21532-13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates. W White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fire Apparatus Sales Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Agnes Scollick Alexander Speir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland 13523 Old Legislative Road Dave Speir Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** May 20, 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pulsolas Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) Circhosis 14961 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to ( r as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial. by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) Yes g Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2. No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

e Funeral Director. After this certificate has autopsy 1 Yes 2 No Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Accider
☐ Suicide filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5-20-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Drive, Cumberland, MD Christopher Vagnoni 32. Registrar's Signature arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	Department of Health ar Certificate of Death		- 2011 18132						
			Registrar  1. Decedent's Name (First, Middle, Last)	Cortinoate or Boati	2. Date of Death	g. No. 3. Time of Death						
	Physicia Medic		Paul Otto	Schaefer	Month	3 Pay 301/ 0923 M						
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of I	Death	4c. County of Death						
			Western MD Regional Medical Center			Allegany						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birti	Months Days Hours	Min. (Month, Day, Y	9. Birthplace (State or Foreign Country)						
-	Director		150-30-0900   1 X M 2 L F   69	Yrs.	09/13/1	Year) Country) 1941 New Jersey						
	and show	ō	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits						
	Maryl 28a-f otified	rec	MD Allegany	Cumberland		1 ☐ Yes 2 🏋 No						
	h the	al Di	10e. Street and Number	10f. Zip Code		og. Citizen of What Country?						
	th wit ms 23 must	Funeral Director	13825 Maple Tree Lane, SW	215		USA						
<b></b>	or iter	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.						
99	s afte ral", c Exan	q pe	3 Widowed 4 X Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:		Specify: White						
2-0	hour natu	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of	f working 1	6b. Kind of Business Industry						
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р Б	ed wil Hygie other ent, th	a l	12 2 2	Police Offi	S Name (First, Middle, Ma	State Government						
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If the Z7 is marked other than "natural", or items Z3a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	입		_	Pauline	Greiner						
ary	hould and N is ma	1	19a. Informant's Name/Relationship (Type, Print) 19b	Mailing Address (Street and Number of	or Rural Route Number, C	City or Town, State, Zip Code)						
Σ	ealth m 27		Paul Stoker / Son P	.O. Box 97, Ft. As	shby, WV 2	26719						
ore	pe 1 an t of H If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of cemeter	Disposition (Name of y, crematory or other place)	Date 2	20c. Location - City or Town, State						
턡	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify) / Cumber	rland Crematory C								
Ba	perm Depa Impo any ii		21. algoriture of Funeral Service Livere	22. Name and Address of Facility  404 Decatur Stre		Ly Funeral Home, P.A.						
			23a. Part 1. Enter the disease, or complications that caused the death. Do r									
	hysician/	0.8	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	GIC STRA	NE	Interval Between						
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	Examiner	<u>.</u>	Sequentially list conditions, b.									
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09	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dical Examiner	d									
876	tificate ng phy as th		IF FEMALE:									
Box 687	th cert tendir	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death			23d. Date of delivery						
Bo	e deal the at hed fo	Physician/Me	1  Yes 2 No 4 Pregnant at time of death 9 Unknown	5 U Other (specify)		Month Day Year						
Records, P.O.	hat the ed by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?						
s, I	uires t n signi lid be	q pa	SEPTIC SHOCK		1 🗆 Yes	s 2 No 3 Probably 4 Unknown						
ord	w require s been si should I	plete	ACUTE RENAZ FAILU	RF	24a. Was an							
3ec	The lar	Completed by			— autopsy perform	ned? death?						
E	sian:   ertifica ctor, p		25. Was case referred to medical examiner?	26. Place of Death								
⋛	Physic this co	은	1 Yes 2 Polo Hospital: 1 Hapatient 2 ER/Ou			nce 6 Other (Specify)						
n 0	ding F h. After funera	ate	Natural 5 Pending (Month, Day, Year) i	ime of 28c. Injury at work?  M 1 \sum Yes 2 \sum N	28d. Describe hov	w injury occurred						
Sio	Atten	Certificate:	'2			eet and Number or Rural Route Number,						
Division of Vital	al Dire		building, etc. (Specify)		City or Town,	State)						
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check Deck of Medical Examiner: On the basis of examination and/c	death occured at the time, date and pla	ace, and due to the cause	e(s) and manner as stated.						
	thin 2,	Me	only one) 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifier	edge, death occurred at the time, date a	nd place, and due to the c	cause(s) and manner as stated.						
	ん? ち <u>き</u> ちゅ		Mullion Jam MD	29c. License number  D 20 2 5		Pd. Date signed (Month, Day, Year)  PAY 24, ZO[]						
	4.2		30. Name and address of person who completed cause of death (Item 23a) (			l						
			30. Name and address of person who completed cause of death (Item 23a) (William Lamm, M.D., 12500 Willo	wbrook Road, Cumbe	erland, MD	21502						
	Stat Registra	te	31. Date filed (Month, Day, Year)  NAY 25 2011  32. Registrar's Signature	barkel								
	negistr	ell.	Beneva G.	La arras								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month 2011 02:28 AM Physician/ Betty Catherine Smith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MICOMICO Salisbur Hospica Chastal at 9. Birthplace (State or Foreign If Under 1 Year | If Under 8. Date of Birth Social Security Number **Funeral** Feb. 8 Maryland Min. 1 M 2 X F Months Hours 93 221-07-2389 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 X No Salisbury Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21804 30605 Berwyn Circle 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Year or Dates 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Anna L. Beauchamp ဂ Ernest L. Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Salisbury, MD 30605 Berwyn Circle (Daughter) Mary Mills Libengood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 Cremation 3 Removal from State St. Stephens CemeteryMay 16, 201 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 19940 13 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BMEN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Que to for as a nonsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and use as the burial-trar Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day Year in the past 12 months? ate has been signed by the atterpage 2 should be detached for Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 Yes /2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Other: 4 Nursing Home 5 Residence Cother (Specify) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Natural 28b. Time of 28c. Injury at work' 5 Pending 1 🗌 Yes 2 🗐 No within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 31. Date filed (Monta

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gistrar's Signature

33 stub Bury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Physician/ Ruth Ann Taber 19.25 pm Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany WM Regional Medical Center Cumberland 5. Social Security Number 234–40–3386 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. March 25 1928 District Colum 1 M 2 X F Months Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Allegany Cumberland 1 Yes 2 No 10f. Zip Code 21502 10e. Street and Numbe 10g. Citizen of What Country? United States 210 Forest Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 XMarried 1 Yes 2XXNo If Yes, Give Year or Dates. white 1 ☐ Yes 2XXNo Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harriette Wierer Wright Welton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Forest Drive, Cumberland, Maryland 21502 Willard Taber/ husband 20b. Place of Disposition (Name of 20a Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State Philos Cemetery 05/29/2011 Westernport Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ CARDINGENIC SITUCIO 104RS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions Examiner Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 🗙 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIMBETES 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION autopsy 1 ☐ Yes 2 🗷 No 1 Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 잍 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No X Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature ape 29d. Date signed (Month, Day, Year) MAY 26, 2011 +111) DUO33417 (ennizaro) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 1068 NATIONAL HICHWAY LAVALE, MARTLAND JAMES R. MOEN MD egistrar's Signature 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Mareva Ellen Teets May 17, <sup>□</sup>2011 8:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Garrett Grantsville Goodwill Mennonite Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Jan. 4 Days 1 M 2 X F 1925 Maryland **Director** 212-20-5312 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Garrett Swanton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1010 Bittinger Rd. 21561 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Postal Service Postal Clerk 12 Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Goldie Wilson John Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Glotfelty/Daughter 111 North Glade Hill Dr., Swanton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrett Co. Mem. Gardens May 20, 2011 Oakland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interest or injury Exami and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last nding physician a use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 2 🗌 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide 5 Pending work within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 000 Hoer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 7/2009 MAY 23 2011

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $\overset{\text{Day}}{2}0\underline{1}\underline{1}$ Physician/ Month Turner May Lula May 17 6:55 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Fairland Adventist Nursing & Rehab. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, ept. 20 9. Birthplace (State or Foreign Country), NC Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🛣 F Months 056-16-4750 Director 1915 Sept. Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Silver Spring 1 Yes 2 X No MD Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral USA 20902 716 Hermleigh Road items death v 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or ite Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Specify.Black Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) within 7 Elementary/Seconday (0-12) College (1-4 or 5+) the B. Altman & Co. 10 Clerk permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Amy Hussey Leo Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 716 Hermleigh Road, Silver Spring, MD 20902 Paula K. Simmons/Niece Baltimore, Date 18 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State May Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011Alexandria, VA 21. Signatu Francis J. Collins Funeral Home Inc. ole 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or coronlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Examiner since 2007 b. Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami requires that the death certificate be executed Coronary Artery Disease Due to (or as a consequence of) inding physician use as the burial Physician/Medical <sub>d</sub>Hypertension P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery foru Ectopic pregnancy in the past 12 months?
1 Yes 2 XXNo 5 Other (specify) Month Day Year Pregnant at time of death ed by the detached signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>و</u> Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law i within 24 hours after cleath.

To the Funeral Director. After this certificate has be propropered filled in by the funeral director, page 2 s. autopsy performed Yes 2 XN Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 😾 Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) 1 🗌 Yeş 2 K No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 5 Pending 1 Natural injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) R151747 May 18, 2011 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, Rockville, MD 20850 Nkiru Juliana Ezeani, CRNP

State Registrar 31. Date filed (Month, Day, Year,

MAY 20

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2

		- For State Registrar	Certificate of	Death	F	leg. No.			
Physicia	_	Decedent's Name (First, Middle,Last)			2. Date of Dea Month	Day Year	3. Time of Death 1836 hrs		
edical Exami		Michelle Leigh Vinson			May 24, 2	2011 4c. County of Dea			
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Location  Waldorf	on or Death	Charles			
		3212 Bethesda Drive	(In yrs. last birthday)		Inder 24Hrs. 8. Date of B	irth (MM/DD/YYYY) 9. B	irthplace (State or		
Funeral Director		5. Social Security Number 2.1.6. Sex 17. Age 1 M 2XXF	39 <sub>Yrs.</sub>			BER 03. Fore	eignWASH, DC		
any .	-	Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Location	on			10d. Inside City Limits		
	jo.	MD CHARLES		WALDOR		10g. Citizen of What Co	1 Yes 2XX No		
the Mary	Dire	10e. Street and Number 212 BARKSDALE AVE.		10f. Zip Code 20602		UNITED ST	rates		
death with r items 23 nust be ng	Funeral		X No	es, specify Cuban, Mexi	Origin? ( Specify Yes or N ican, Puerto Rican, etc.)	White, etc.	erican Indian, Black,     ITE		
after	Đ.	3XXWidowed 4 Divorced If Yes, Give Year or Dates:	Call	Yes 2XX No spec		Specify: 16b. Kind of Busines	s/Industry		
MD 21215-0036 2 should be filed whitin 72 hours after death with the Maryland h and Menta Hygieneth 172 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-fahu 27 is marked other than "natural", or items 23a or 28a-fahu mustic event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (Specify only highest grade complete interpretary) Elementary/Secondary (0-12)  College (1-4 or 5-12 TH	during me	ost of working life. DO N			C/PRIVATE		
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be Com	17. Father's Name (First, Middle, Last) ROBERT HARRISON JONES,		1208	ther's Name (First, Middle, STINE VIRG	INIA CUTS			
, MD 21, and 2 should be ealth and Men fem 27 is mar traumatic eve	٥	19a. Informant's Name/Relationship (Type, Print ) BRETTANY N. JONES /DAUG	HTER 212	BARKSDALE	Number or Rural Route Nu E AVE . , WAI	LDORF, MD	20602		
O 7 7 7 1		20a. Method of Disposition  1 Burial 2 XX cremation 3 Removal from Stat  4 Donation 5 Other Specify:	Place of Dispose RIVERDAL CREMAT	ition (Name of cemetery DE PARK ORY	MAY 31, 2011	20c. Location - City RIVERD	ALE, MD		
Baltimord permit. Pages I Department of I Important: If		2/Signature of Funeral Serv JOHNSON #MO			PLAINS LAI				
Physician		23a. Part I. Enter the disease, or complications that caused t failure. List only one cause on each line.	he death. Do not enter to	he mode of dying, such	as cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death		
Medical Examiner	Immediate Cause (Final disease a Chronic Narcotism								
		or condition resulting in death)  Due to (or as a consection)	quence of):						
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):						
uted Id ransit	Exa	events resulting in death) Last  Due to (or as a conse	quence of):						
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760, cate be physic he bur		IF FEMALE: 23c. If yes, outcome		. OF-		23d. Date of deliv			
Box 687 ne death certific the attending p	Physician/	23b. Was decedent pregnant in the past 12 months?		etal death 3 Ed ther (Specify)	ctopic pregnancy	Month	Day Year		
SOX death e atter for u	ysic	1 Yes 2 No 9 V Unknown 9 Unknown	3 🗀 0	ner (opecity)		6			
O. Entrie of		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given		tobacco use contribute			
F, P.O. ires that the signed by the detached	d by		<u> </u>		1Y		robably 4 🗸 Unknown		
ords, w requir is been s should	Completed				24a. Wa		autopsy findings available to completion of cause of		
e law e has ge 2 sj	ш					formed? death			
Rec		25. Was case referred to medical		26.Place of D	eath (Check only one)				
Vital Pysician: ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatien	t 3 DOA Othe		Residence 6 🗸 Ot	her: Scene		
Of Ning Phy		27. Manner of Death 28a. Date of Inju (Month, Day,Yu	ry 28b. Time of ear)			e how injury occurred			
ion trendi leath. tor:	atio	2 Accident Investigation		1 Yes		(Otana) and Number or	Burat Boute Number City		
Division of Vital Records, ral or Attending Physician: The law require as after cleath. Director: After this certificate has been sited in by the fineral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	jury - At home, farm, stre	et, factory, office buildir	or Town		Rural Route Number, City		
Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Direct After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner:On the basis of example of the basis of the basis of example of the basis of example of the basis of the	/ knowledge, death occu nination and/or investiga	irred at the time, date ar	nd place, and due to the ca ath occurred at the time, da	te and place, and due to	stated. the cause(s)		
To with Con	Mec	29b. Signature and title of certifier		29c. License nur		29d. Date signed (			
		Column		O.C.M.E		May 25, 2011			
<u> </u>		30. Name and address of person who completed cause of d	eath (Item 23a)						
234		Zabiullah Ali, M.D. Assistant Medical Ex		Baltimore Street, I	Baltimore, MD 2122	3			
S Regis	tate trar	WIND 0 0014 M	r's Signature	Cal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Margaret Watkins 2:00 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 TXT Months Hours Wash., D.C 03/15/1937 579-50-2060 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Md. P.G. Landover 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7606 Burnside Road 20785 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 😾 Married Completed by 1 Yes If Yes, Give 2 X No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Secretary Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert E. Lee Sarah Moye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Maurice A. Watkins/Husband 7606 Burnside Road, Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Mem. Park 05/27/11 Landover, Maryland 22. Name and Address of Facility Henry S. Washington 4925 Burroughs Ave., N. Signature of Funeral Service Licensee Sons Co., Inc., Washington, D.C. ass 20019 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) the i g 🗌 Unknown g 🗌 Unknown signed by the best of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2-110 ၉ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical i 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENICWORTH AVE, RIVERDALE MD 31. Date filed (Month, Day, Year, State MAY 2 5 2011 Registrar

DHMH 17 Rev 7/2009

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Physician		Registrar 1. Decedent's Name (	First, Middle	Last)			i imodio o	Doge			2	. Date of Deat		-	3. Tim	e of Death
Medical Examine		Jessica	Robin	Webb								Month May 16, 20	Day 011	Year	10	46 hrs
	•	Jessica 4a. Facility Name (if n			t and numi	ber)				ocation of	Death			ounty of Dea	th	
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Funeral	1	5. Social Security Nur	mber	6. Sex	7.	. Age (In yrs. I	ast birthday)	If Und	s Days	If Under:	24Hrs. Min.	8. Date of Birt	h(MM/DE	Fore	ign	
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	-	Quan T	)						O.C.N					17, 2011	, _ •	
P	+	30. Name and addres	s of person	who comple	eted cause	of death (Item	n 23a)			-				-		
4111		Ana Rubio MI	•				900 W. Bal		Street, E	Baltimore	e, MD	21223				ĺ
Sta		31. Date filed (Month.	Day, Year	2011	32. leg	istrar's Signat	D. As	Mal								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Regional Medical WMHS Alleganu Cumberlance If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F (Month, Day, Country) Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10d. Inside City Limits Completed by Funeral Director BEDFOR HYNDMAN 1 Yes 2 W No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Countr View Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes. Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Kestaurant Waitres 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည COOK BLOUGH NOAH PEARL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cumberland MD 21502 Butternut Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5-21-11 HUNDMAN HUNDMAN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HARVEY H. ZEIGLER Signature of Funeral Service Ligenses ST HYNOMAN PAISSUS FUNERAL Home 169 Clarence Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final √hysician/ TIVE disease or condition resulting in death) CONCES Medical Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 2 No 1 Inpatient 2 K ER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie D2690 HIchin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 BISHUP WALSH RO CUMBERLAND MO MEL HARJIT STOHU State 2011 Registrar

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	Dhyminia	./	1. Decedent's Name (First, Middle, Last)			2. Date of Death  Month  Da	Year 3. Time of Death
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ا	Examin	er	218 Phillip M	orris Drive	Salisbury	<u> </u>	Vicomico
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda) 7. Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	2 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	- 1	10a. State 10b. County	10c. City, Town or	ocation		10d. Inside City Limits
	within 72 hours after death with the Maryland glent. er then "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at t, the Medical Examiner must be notified at	声	Mary and Wicomin	1 1 0	10f. Zip Code	10g. C	itizen of What Country?
	ath with	Funeral	SOG LEVIN 12	Was Decedent Ever in U.S.	3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
99	fter dea ', or ite aminer		1 Never Married 2 Married	Armed Forces?  1  Yes 2 No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1  Yes 2 No Specify:	Hican, etc.)	Black, White, etc.  Specify:   D  1
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215	iin 72 h ie. <b>han "n</b> <b>e Medi</b>	dwo	(Specify only highest grade  Elementary/Seconday (0-12)	College (1-4 or 5+) (Gi	ve kind of work done during most of work DO NOT use retired)	King A	diff Day Corp
	filed within al Hygiene. d other tha vent, the l	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Maider	Surname)
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Maryland	1 and 2 should be filed within 72 hour f Health and Mental Itygiene. item 27 is marked other than "natun other traumatic event, the Medical	l	19a. Informant's Name/Relationship (Type,	Print) 19b. M.	ailing Address (Street and Number or Rul	()/2 001	or Town, State, Zip Code)
	1 and 2 s of Health item 27 i		20a. Method of Disposition  1 Burial 2 Cremation, 3 Re		sposition (Name of rematory or other place)		Location - City or Town, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or conce.		4 Donation 5 Cther (Specify)	Zion (	MC Cemetery May 22. Name and Address of acility	21,2011 Sh	arptown, Maryland
Ba	permit. Departr Imports any inji		21. Signature of Funeral Services Licensee	1.	Funeral Home Po	Priv 27.	Bridgeville DE
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
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68760	sertifica Iding pl	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy		9	23d. Date of delivery
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Records,	e law r e has b ge 2 sk	Jdwc				autopsy performed	prior to completion of cause of death?
al B	ian: Th irtificate ctor, pa	Be C	25. Was case referred to medical examiner?		26. Place of Death (Che		
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o uo	ath. r: After ne fune	icate	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) inju	ry work? 1 ☐ Yes 2 ☐ No		
Division of Vital	after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Medical	(Check 2 Medical Examine	e. On the basis of examination and/or it	ath occured at the time, date and place, nvestigation, in my opinion, death occurred ge, death occurred at the time, date and p	at the time, date and bla	ace, and due to the cause(s) and manner stated.
	To the within 2 To the Comple	Ž	only one) 3 L Certifying Nurse 29b Signature and title of certifier	Practioner: To the best of my knowled	29c. License number		Date signed (Month, Day, Year)
			1020	LU, MO	07627		7/11/11
			30. Name and address of person who cou	mpleted couse of death (Item 23a) (Ty	HOSPILE POB	0x 1733	Salsh mo 2180;
	Sta Regist	ate	31. Date filed (Month, Day, Year)	3. Registrar's Signature	backer		Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frances Lucille Walter May 24, 2011 6:30PM м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Care 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Maryland 1 - M 2 XF Days Hours Min March 17 1929 82 **Director** 215-26-8002 Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Director ıral", or items 23a or 28a-f s Examiner must be notified Maryland Howard Columbia 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 6336 Cedar Lane, Apt. 358 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White "natural", Completed 3 X Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. d other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Lucille Virts 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or con-မ Howard Stup 19a. Informant's Name/Relationship (Type, Print) Mrs. Debra L. Sundberg, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 4958 ValleyView Overlook, Ellicott City, 21042 20a. Method of Disposition
1X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mt. Ulivet Cemetery May 28, 201 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pyneral Service Lic 22 Keeney and Basford PA Funeral Home M00255 East Church St., Frederick, MD 21701 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Approximate Interval Between Opset and Death Immediate Cause (Final Ph\_sician/ METASTATI UNTH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of if any leading to immedi cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Day Month Year Pregnant at time of death detached Unknown been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORUNARY ARTERY DISEASE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed HYPER TENSION 24b. Were autopsy findings available 24a Was an page 2 autopsy prior to completion of death? 2 No 1 Yes Be 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spe 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner 🎢 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury · Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name an address of person who complete Date filed (Month, Day, Year, State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-03806 State of Maryland / Department of Health and Mental Hygiene Wendell Ellis Youngblood 1. For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month 0228 hrs Medical Examiner May 21, 2011 WENDELL ELLIS YOUNGBLOOD c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** country) MO Months Days Hours Director 08/20/1945 350-36-6819 1 X M 2 F 65 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince George's 28a-f sho Suitland Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 4904 Keir Court 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces' 1 Never Married 2 Married 1 X Yes Specify: Black 4 Divorced If Yes, Give Year 1965-68 1 Yes 2 X No specify: 3 X Widowed <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 DC Fire Department 1 - 4Fireman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma J. Hadley Louis C. Youngblood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) thent of Health and Itant: If item 27 is 6810 Haven Ave., Oxon Hill, MD 20745 Lakisha Youngblood/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06 - 02 - 2011Cheltenham, MD MD Veterans Cem. 4 Donation 5 Other Specify: 22 Name and Address of Facility 21. Signature of Funeral Service Licensee Cedar Hill FH,4111 PA Ave., Suitland, Approximate Interval Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Torso Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Exa events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician for use as the burial -Division of Vital Records, P.O. Box 68760, talor Attending Physician: The law requires that the death certificate be to 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ģ 1 Yes 2 No 3 Probably 4 Unknown pleted ificate has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical å examiner? Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28d. Describe how injury occurred 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death May 21, 2011 Driver auto fixed object collision Certification 1 Natural 0152 hrs 1 Yes 2 ✔ No Pending To the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) 3554 Bladensburg Road, Cottage City, Md. determined (Specify) Local Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month. Day, Year)

State Registrar

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Month, Day Year, WAY 2 5 201

Quasille 30. Name an address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar Signatu

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

May 21, 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 1<sup>D</sup>6<sup>y</sup> 20 ÎÎ 15:10 P M Physician/ Mable Elizabeth Young Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 M 2 X F Days Hours Months 98 1912 Washington, D.C. **Director** 577-18-5942 Usual Residence of Decedent show 10d Inside City Limits 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 1X□ Yes 2 □ No Waldorf Maryland | Charles 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral USA 20601 3006 Hickory Valley Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Home Maker 12th. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Sadie Virginia Wood Herbert Joseph Sweeney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3006 Hickory Valley Dr. Waldorf, Maryland 20601 Mary Margaret Condon 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State Waldorf, Maryland May 21, 2011 4 Donation 5 Other (Specify) Crematory 22. Name and Address of Facility Huntt Funeral Home Signature of Funeral Service Licensee 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Spiration Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 5 Other (specify) 1 Yes 2 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (D 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No 1 ☐ Yes 2 ☐ 26. Place of Death (Check only one) 25. Was case referred to medical examiner? completed filled in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To 1 🗌 Yes 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Pwithin 2. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 046478 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Survatts Rel Clinton MYEST 501 101 Date filed (Month, Day, Year) State MAY 23 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20c per fh 9916 6-7-11 yt
State of Maryland 7 Department of Health and Mental Hygiene
State amend #20b, 20cperfhg916 6-22-110.0.
Registrar amend #19b per FH C917 7/07 Politicate of Death

1. Decedent's Name (First, Middle, Last)

2. Date of Death 2. Date of Death Physician/ <sup>Day</sup> 2011 May 16, Wayne T. Young 2109 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverly Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** . Age (In yrs. last birthday g. Birthplace (State or Foreign 8. Date of Birth Country)
Wash.,DC 1 **Ϫ**M 2 □ F Months Days Hours Min (Month, Day, 578-78-4169 Director 55 ,1956 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits DC 1 XYes 2 ☐ No Washington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 23a 305 Anacostia Ave., NE 20019 United States items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? 0 Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) event, the Pipe Layer Private 1 and 2 should be filed w of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Young Louise Eldridge 19a. Informant's Name/Relationship (Type, Print) 193701g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3401 Donnell Forestville, Bbive0#393 Department of Health Important: If item 27 any injury or other trong once. Wanda Porter-Young/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Landover, MD . Page 1 6/24/11 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery tramatery or other place) unk Unk Unk Suitland, Md. Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Cardiac Arrest Medical resulting in death) Due to (or as a consequence of) **Examiner** Ventricular Fibrillation Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical certificate be Box 68760 the as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown ō 4 Pregnant at time of death
9 Unknown Month Day Year the detached P.O. þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an Were autopsy findings available certificate has breaked to be rector, page 2 s autonsy prior to completion of cause of perform death? 1 ☐ Yes 2 ☑ No Yes 2 i the Hospital or Attending Physician: I hin 24 hours after death.
the Funeral Director: After this certifies 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) 2 1 Yes 2 12 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd., NE, #201, Wash, DC Norman M.D., 1647 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 RONALD VIRGIL ZILER กัว 2011 1335 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 03/29/1935 Months 220-32-2544 Director 76 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2X No Allegany Mt. Savage 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 17305 Dutch Hollow Road, N.W. 21545 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Mt. Savage Specialty Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Worker Refractories permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Carl Donald Ziler Bernice Opal Hodgen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Maxine Ziler / Wife 17305 Dutch Hollow RD, NW, Mt. Savage, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Meml.Park 05/12/2011 Cumberland, MD 22. Name and Address of Facility Upchurch, Funeral Home, 21. Signature of Funeral Service Licensee CALL 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a considence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has SlipiDemiA 1 ☐ Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🕱 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or recovery within 24 hours after death.

To the Funeral Director: After thi

"monieted filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 2 🗌 No 1 Tyes Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my calable, death accurred to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying Nurse Practioners To the best of my knowledge, deeth. conversed at the time, date and place, and due to the cause(s) and manner as static 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Mds

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egrina

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Londolenn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Alek Sundrowi'(Z 10:42 P M Physician/ Edward 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Peartree Assisted Living Pasadena 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1X M 2 D F 7. Age (In yrs. last birthday) Social Security Number Days **Funeral** Months (Month, Day, Year) , 192 Maryland 87 Director 220-14-0923 Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Director 1 🗆 Yes 2 🏝 No Anne Arundel Pasadena Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA with 21122 438 Park Creek Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? No 1943 - 1945 1 ☐ Yes 2 No Specify: 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 SpeciWhite If Yes, Give 3 X Widowed 4 Divorced Year or Dates. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Auto Sales Elementary/Seconday (0-12) Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kathrine Hajewski ည Constantine Aleksandrowicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 438 Park Creek Road Pasadena, MD 21122 Young (Daughter) Kathy 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Jun 07 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dundalk, MD 2011 Holy Rosary Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Stallings Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3111 Mountain Road Pasadena Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death) Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition End-Stage Dementia Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Month in the past 12 months? 1 Yes 2 No Unknown the been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 s performed? Yes 2 N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Certificate: work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifer 29c. License number nslagapatre M.D D0057 465

12+1

State 31. Date filed Month, Day, Year)
Registrar

N.S. Rujapakse, M.O. 2835 Smith Av

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

MO 21209

Balhmore,

5-203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2017 a DONALD BENNETT AULL JUNE 5:45 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MA MAISON ASSISTANT LIVING PERRY HALL BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Davs Hours Min. (Month, Day, Year) 6/22/1929 MARYLAND Director 214-24-4233 81 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director PERRY HALL 1 Yes 2 X No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral items 23a 3405 PARKFALLS DRIVE 21236 USA permit. Page 1 and 2 should be filled within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked other thousany injury or other the state of the 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 □ No þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates. KOREA WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) BALTIMORE CITY POLICE Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE PATROLMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HARRY AULL CARLOTTA BENNETT 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 PARKFALLS DRIVE PERRY HALL, MD 21236 DONALD B. AULL/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 6/6/2011 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 150020 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and de detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death a I IInknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 DNo 1 Yes 3 Probably 4 Unknown Completed a process. 124 hours after death.

• Funeral Director: After this certificate has been a Funeral Director. After this certificate has been a fine and in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTANT LIVING Other: 4 Nursing Home 5 Residence Hospital: 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 😾 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniurv 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 [ only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 66 201, 30. Na e and address of person who completed cause of death (Item 23a) (Type, Print) MO

State Registrar JUN 0 8 2011

32. Registrar'

aerville

21234

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Heath and Mental Hygiene 1 | 1 | For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Day Bernice Veronica Acree 2:20 p M 6 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore County Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) -17-1950 1 □ M 2 🔀 F Director MD 212-56-8271 60 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔽 No Baltimore County Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 1609 N. Bradford Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ ò 1 Never Married 2 Married within 72 hours after Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give Specify: and Mental Hygiene. is marked other than "natural", 3 Widowed 4 X Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) John Hopkins Hosp. Housekeeping 11th N/A Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other. ೭ Bernard Brown Fannie Lewis 19a. Informant's Name/Relationship (Type, Print) **Fannie Lewis** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Cecil Ave. Baltimore, MD 21218 Fannie- Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemeter, crematory or other place)
Druid Ridge Cemt. 6/10/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer \* Pervice Lice \*\* 22. Name and Address of Facility March F/H Ave. Baltimore, MD 21202 1101 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 34 Physician/ disease or condition resulting in death) Lear Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year been signed by the should be detached Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this **the Funeral Director**: After thi npleted filled in by the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 71040 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NCHARLES ST RAJIMORIE 710 KUMAR Spits 4105 31. Date filed (Month, Day, JUN 0 8 2011 Pagistrar's Signature 32. Registrar

State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:35 am Medical Examiner ity Name (if pot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kichey Baltimore HOSPice If Under 24 Hrs 9. Birthplace (State or Foreign vrs. last birthday) Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Hours Min Director or 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside Cjty Limits death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at by Funeral Director Baltimore MD 1 Yes 2 No 10f, Zip Code 10e Street and Number 10g. Citizen of What Country? 21216 Rosedale USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working av (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) ပ္ wrence ra . Informant's Name/Relation hip (Type Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Ro 2508 N. Koseda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 20-4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee 21. Signatu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 ☐ Probably 4 ☐ Unknown Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed: the Hospital or Attending Physician: The After this certificate 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HUSDICE Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Investigation

Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month, Day, Year) State JUN 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Brokley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) June 1:45PM Physician/ Faith Lillian Bennett Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore City 4205 Valley View Avenue 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** (Month, Day, Year) -23-1943 1 □ M 2 🛛 F Months Min. 68 Yrs 216-36-7520 Director Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore City MD N/A10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21206 4205 Valley View Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give White Completed 3 Widowed 4 Divorced ear or Dates 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Empire permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) N/A Elementary/Seconday (0-12) Exterminating Bookeeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Mae Mohr William <u>Carl Harris</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6270 Owls Nest Rd. Seaford, DE 19973 Brenda Widerman/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 6-7-2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA Signature of Funeral 1201 Dundalk <u>Avenue Baltimore, MD 21222</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mon Physician/ MIKO disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Ectopic pregnancy Month Year Day in the past 12 months? After this certificate has been signed by the atter funeral director, page 2 should be detached for Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3i ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director; 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) Hospital: 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE ÒU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Novin HaVles 5901 m.D Don 31. Date filed (Month, Day, Year) 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JÜNE 2019 JOHN A. CLENDENIN 10:07 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GILCHRIST CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** Days Country) (Month, Day, Year) 10/11/1948 1**X** M 2 □ F Director 220-50-3416 62 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d, Inside City Limits within 72 hours after death with the Maryland Director MD 1 Yes 2 X No BALTIMORE NOTTINGHAM 10e. Street and Number 10g. Citizen of What Country? Funeral 35 SLAVIN COURT 21236 usa 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, , or ! 1 Never Married 2 XMarried Completed by 1X Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 Widowed 4 Divorced WHITE Year or Dates VIETNAM traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) CORRECTION OFFICER STATE OF MARYLAND 12TH GRADE is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN HENRY CLENDENIN CLEMENTINE BLEVINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau VICTORIA E. CLENDENIN/WIFE 35 SLAVIN COURT NOTTINGHAM, MD 21236 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 6/7/2011 METRO CREMATORY. INC. CATONSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ INCF Canc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 2 No 1 Yes ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No ္ဝ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After completed filled in by the funer. 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD HARVES 701 JUN 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June 2011 ear 2:23а м Julia C. Crisco 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare- Heritage Center Dundalk Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Dav. Year) 1 - M 2 - F Months Days Hours Min 220-66-2402 Director 58 Tanuary 5, 1953 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Md. Dundalk 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 7501 School Ave. 21222 USA or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates. ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other tha 12 years N/A Never Worked Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Crisco Dorothy Thomas : If item 27 is marked or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Crisco Father 7501 School Ave. Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of M 1 Burial 2 Cremation 3 Removal from State June 8, Important: I any injury o Middle River, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial 2011 Sign wre of Fuy ral Service Licens Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock; or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last attending physician for use as the hurial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 🗗 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy prior to completion death? 1 Yes the Hospital or Attending Physician: 25. Was case referred to dical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural work? 5 Pending 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Z Month Year Physician/ Purcell 10:00 PM Carter June 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Baltimore Season's Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number . Age (In vrs. last birthday) **Funeral** Min. Month, Months Hours 1 X M 2 🗆 F Director MD 225-32-6538 Dec "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Baltimore Baltimore 1 🗌 Yes 2 😾 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 7202 Place Seymour USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 V Yes 2 No If Yes, Give 10/11/48 Year or Dates. 8/1/50 Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐xNo Specify: Black Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Meany injury or other traumatic event, the Meang life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service <u>Accident Investigator</u> NA Be Father's Name (First, Middle, Last) Emory Carter 18. Mother's Name (First, Middle, Maiden Surname) Nadine Curry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Ralto MD 21207 19a. Informant's Name/Relationship (Type, Print) 7202 Seymour Place Muriel Carter - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Owings Mills, MD Plonation 5 Other (Specify) 6/10/2011 Garrison Forest VA Signaure 22. Name and Address of Facility 22. Name and Address of Facility

4300 Wabash Ave.

March Funeral Home West, Inc. Baltimore, MD 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cardioThrombot C Event Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Atherosclerotic enrali orascular Distase Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed' 2 No 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 🗌 Yes 2 🗷 No <u>မ</u> 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 124 hours after death
le Funeral Director: A
bleted filled in by the f Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) US RAJApalare M.D D0057465 6/3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MO 21209 2835 Smith AV N.S. Rajapa KSE, MO 5-203 31. Date filed (Mostin Pay Year) 2011 Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jacob Kalen Clark	1- For State Cert	rtment of Health and Mental Hygiene tificate of Death	2011 1815								
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)  Jacob Kalen Clark      4a, Facility Name (if not institution, give street and number)	2. Date of Month June 2	Day Year 1051 hrs								
	Johns Hopkins Bayview Medical Center	Baltimore									
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 215 – 87 – 6542 1XM 2F		F Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD								
I wow any	Usual Residence of Decedent  10a. State 10b. County 10c. City, 1  MD Baltimore Co. Ess	Town or Location	10d. Inside City Limits 1 Yes 2 X No								
Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Realth and Mental Hygiene.  Hant: Witen 27 is marked other than "matural", or items 33a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10e. Street and Number  905 Virginia Avenue	10f. Zip Code 2 1 2 2 1	10g. Citizen of What Country?								
r death with t , or items 23a Cmust be not Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2 No		<u> </u>								
hours after or natural", o	3 Widowed 4 Divorced of Divorced or Dates:	1 Yes 2 X No specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Specify: White  16b. Kind of Business/Industry								
5-0036 led within 72 hour other than "natu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  O  17. Father's Name (First, Middle, Last)	N / A	N/A								
21215-0036 total be filed within 7 d Mental Hygiene. s marked other than the event, the Medica To Be Comple	19a. Informant's Name/Relationship (Type, Print )	Ashley Mulli	ns								
e, MD l and 2 sho Health and item 27 is r traumati		905 Virginia Avenue Es	SSEX, MD 21221  20c. Location - City or Town, State								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Bullar 2 A Gremation 5 Removal nom state	yview Crematory 6-4-201  22. Name and Address of Facility Kaczoro	owski Funeral Home,P								
Physician Modical Examiner	23a. Fait I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Asphyxia										
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  C.										
50, te be executed ysician and burial - transit ledical Examiner	events resulting in death) Last  Due to (or as a consequence of)  d.	); 									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown g Unknown	2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year								
res that the c signed by th be detached			id tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown								
Vital Records, ysicias: The law requirer his certificate has been significate page 2 should be o Be Completed		p	/as an utopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No								
/ital Rec	25. Was case referred to medical	26.Place of Death (Check only one)  ER/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other:								
ion of Victorian Physical distribution: To attention or After this the funeral distribution: To attion: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury 1840 hrs  28c. Injury at Work? 1 Yes 2 ✓ No  28d. Descr	ibe how injury occurred asphyxiated								
Division or Attending within 24 hours after death. To the Funeral Director After completely filled in by the fune edical Certification:	3 Suicide 6 Could not be determined Specify Rowhouse	or Tow	on (Street and Number or Rural Route Number, City n, State) nall Road, Dundalk, MD								
Diwis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	one) 2 Medical Examiner: On the basis of examination and and manner stated.	e, death occurred at the time, date and place, and due to the od/or investigation, in my opinion, death occurred at the time, o	ate and place, and due to the cause(s)								
<b>•</b>	29b Signature and title of certifier	29c, License number O.C,M.E.	29d. Date signed (Month, Day, Year) June 3, 2011								
	30. Name and address of person who completed cause of death (Item 2 Patricia Aronica-Pollak MD. Assistant Medical E	xaminer 900 W. Baltimore Street, Baltimore,	MD 21223								
State Registrar		parket									
DHMH 17 Rev 1/2001	00115	ORIGINAL									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No.-2. Date of Death **Physician** Month TUNE 201 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE
If Under 1 Year | If Under 24 Hrs. AGNES 8. Date of Birth (Month, Day, Year) 10-9-1919 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours 20-8190 1 ☐ M 2 🕶 F Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 28e-f show ortent: If Item 27 is marked other than "natural", or items 23e or 28e-f sho Injury or other traumetic event, the Peological Examination in other 1 Yes 2 0 Director atonsville 10e. Street and Number 10g. Citizen of What Country? usA 21228 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 40 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. pg NOT uselyetired) 15. Decedent's Education (Specify only highest grade completed) dary (0-12) College (1-4or 5+) stodiar s Name (First, Middle, Last) permit. Pages 1 and 2 should be Deperment of Health and Menta Importent: If Item 27 is marked eny injury or other traumetic evone. lox Informant's Name/Rela 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Arbutus, 6-13-2011 21. Signature of Funeral Service Licensee me and Address of Macility Greene Fine ral Services 5151 Balto. Nat'l Pike (21229 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CYLTURE NEGATIVE PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner 10 days COPD EXACERBATION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed CORONARY ARTERY DISTASE Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) □Yes 2 No o 9 Unknown <u>~</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE, BALTIMORE SPAAH 31. Date filed (Month, Day, Year) 32. Redistrar's signature Registrar

DHMH 17 Rev 1/2001

DEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2.21 CLAIRE ANN DANEKER Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner GENESIS LOCH RAVEN PARKVILLE BALTIMORE Social Security Numbe 7. Age (In yrs. last birthdav. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Months Davs Hours Min. (Month, Day, 127/19 Country) MARYLAND 217-60-3105 9 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 XNo MD BALTIMORE PARKVILLE 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 8535 MORVEN ROAD 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) 12TH GRADE College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve once. ပ္ WILLIAM EICHOLTZ CONCETTA GUZZO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES WILLIAM DANEKER/HUSBAND 8535 MORVEN ROAD BALTIMORE. MD20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State DUCANEY VALLEY MEM. 6/8/2011 COCKEYSVILLE, MD 4 Donation 5 Other (Specify) GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOSET? 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate shock, or heart failure. List only one cause on each line terval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Lue lu lui as a consequence un Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregpant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Dav Yea 5 Other (specify) Unknown 9 Unknown been signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy eral Director; After this certificate filled in by the funeral director, pag 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗶 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 X Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and aduless of person who completed cause of death (Item 23a) (Type, Print) 5

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE 1, 2011 LEONARD STANLEY DERNOGA P M 2:27 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1171 BLUEBIRD LANE **CRDWNSVILLE** ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 XX JAN 30, Year) Director 69 212.4D.1197 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 💢 No MD ANNE ARUNDEL CROWNSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21032 USA 1171 BLUEBIRD LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S "natural", or iten edical Examiner r 14. Race - American Indian Arred Forces?

1 Yes 2 If Yes, Give 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha 12 BUSINESS OWNER RETAIL SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CASIMIR DERNOGA MARIE ZYSK other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WIFE 1171 BLUEBIRD LANE CROWNSVILLE, MD 21032 ANNE DERNOGA item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 **XX** remation 3 ☐ Removal from State Important: Il any injury ol **BAYVIEW CREMATORY INC** BALTIMORE, MD 4 Donation 5 Other (Specify) 6.6.2011 of Funeral Service 21. Sign FINK FUNERAL HOME, P.A. CRECORY FINK MD1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Part i Enter the disease, or shock, or heart failure. List 23a. Part complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death nly one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Cong es Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 9 Unknown Yes 2 No the 9 Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate 1 Yes 2 No Yes 2 1 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 24 hours after death e Funeral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 024732 31 10 ss of person who completed cause of death (Item 23a) (Type, Print) le our

State Registrar 31. Date filed (Month, Day, JUN 08

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 AM Carmen Garcia Espinoza 1105 21 Medical 3 / 12 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLin Square Rosedale Ballimore HOSPITal Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**XX**F Days Hours Min. Country) Ecuador 218-83-9734 59 Novth 9 ay, 1951 **Director** Yrs Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore Dunda1k 1 Yes 2 XXNo 10e. Street and Number 50 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medic I Examiner must be by Funeral 8216 Watersedge Rd. 21222 HSA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2XX Married filed within 72 hours after If Yes, Give Year or Dates Yes 2 No Specify. Completed 3 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 3altimore, Maryland 2121 Mental Hygiene. arked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 be f Department of Health and Mente Important: If item 27 is marked any injury or other traumatic eoonge. Manuel Garcia Leonor Espinoza Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) luis Antonio Rivera 8216 Watersedge RD., Dundalk, MD 21222 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ★ Burial 2 ☐ Cremation 3 ★ Removal from State cemetery, crematory or other place) Cemeterio Municipal Cuenca June 12, 2011 4 Donation 5 Other (Specify) Cuenca, Azuay, Ecuador 21. Signature of Funeral Service L Fink Funeral Home, P.A. **Gregoky** 426 Crain Hwy S., Glen Burnie, MD 21061 23a, Part 1, Enter th emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fa Interval Between Onset and Death Immediate Cause (Final Physician/ Bacterial Peritonitis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner circhosis Sequentially list conditions. if any, leading to immediate cause. Litter underlying Cause (Disease or linjury Due to (or as a consequence of) Exam that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 🚅 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1-1No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funei

completed fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific Laure L. Steele 29c. License number 29d. Date signed (Month, Day, Year) 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LarraL STeele 9000 FRANKLIN SQUAVE DR Balto ind 21237 31. Date filed (Month. State egistrar's Signatur Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUNE Physician/ 2011 5:45 A M Susan Mary Eikenberg Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON BALTIMORE MEDICAL CENTER GREATER If Under 1 Year I If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number **Funeral** Months Hours 1 □ M 2 😾 F 53 1957 August 4. **Director** 216-78-0101 Maryland Usual Residence of Decedent 10d Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Dundalk Baltimore 1 Yes 2 No Md. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 3219 Vulcan Road 21222 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16h Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 721 and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Dental Assistant Dental 12 vears injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Elizabeth Rein Gary Elwood Eikenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3219 Vulcan Road, Dundalk, Md. 21222 Sabrina Eikenberg Neice 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 11 1 Burial 2x Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 4 Donation 5 Other (Specify) 2011 Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 21. Signative of Fune al Service License 7110 Sollers Point Road, Approximate Interval Between Onset and Death complications that caused the h. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the diseas shock, or heart failure. List Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Examil Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 the as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown ☐ Yes ☐ ☐ Unknown signed by the a Hospital or Attending Physician: The law requires that the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? cate has I page 2 s 1 ☐ Yes 2 ☐ No this certificate Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Conpatient 2 ER/Outpatient 3 DOA 1 Yes ျ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 8c. Injury at 28d. Describe how injury occurred Medical Certificate: After 1- Natural 5 Pending 1 Yes 2 No Investigation Accident 24 hours after death Funeral Director. completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) avillion State Registrar

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. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death.  Within 24 hours after death.  The Funeral Director. After this certificate has t sen signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	ath 3  Ectopic pregnancy 5  Other (specify)		23d. Date of delivery Month Day Year
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	10		30. Name and address of person who co	ompleted cause of death (Item 23a)	Mpe Print)	1000	June 6, 2011 Byrn M21061
1	, , , , , , , , , , , , , , , , , , ,		1. Date filed (Month, Day, Year)	B 69341	triabin Bl.	vd Chin.	Byrn 4102/06/
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. Na. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3 Time of Death Physician/ Medical Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 🗆 F Days Months Min. 10 11 Country) **Director** 418-38-2808 AL 28a-f show 10a, State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21216 5442 Whitwood Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō Completed by 1 Never Married 2 Married Black, White, etc. Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify 3 😾 Widowed 4 🗆 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12th grade <u>Autique Dealer</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental H Item 27 is marked o မ Alberta Davis Peter Gilchirst and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2801 Gwynns Falls PKWY, Baltimore, Md21216 Ernest Brown-Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 2/2011 Baltimore, 22. Name and Address of Facility

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4300 Wabash Ave, 21. Signature of Funeral Service Licensee elmonde Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) ARCINOM F burlal-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical 68760 use as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy this certificate performed death? 1 🗌 Yes 2 No 2 No Yes 25. Was case referred to medica examiner? funeral director, Be Division of Vital 26. Place of Death Check only one) 2 No ည 1 Yes Other 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yeş 2 No 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one Certifying Nurse Practioner: To the heet of my knowled 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/  $\overset{\mathsf{Month}}{JUNE}$ 2011 2:00 P M 06. JACOB MARVIN HIMMELSTEIN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death BALTIMORE 725 MT. WILSON LANE, #504 BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min 12/21/1922 207-14-8618 88 Director PA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 🗆 Yes 2 😾 No MD BALTIMORE BALTIMORE 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 725 MT. WILSON LANE, #504 21208 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ō 1 Never Married 2 X Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 'natural", Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working al Hygiene. **EPSTEINS** life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STORE MANAGER DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ JULIUS HIMMELSTEIN MINNIE HIMMELSTEIN permit. Page 1 and 2 should I Department of Health and Me Important; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT. WILSON LANE, #504, BALTIMORE, MD MONA HIMMELSTEIN/WIFE 21208 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) OHEB SHALOM MEM. PK. 06/07/2011 REISTERSTOWN, MD Juneral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Š 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final Physician/ ADVANCED DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ Division of Vital Records, DIABETES, CORONARY ARTERY DISEASE, HYPERLIPIDEMIA To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2X N 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) this 27. Manner of Death within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral o 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0054653 June 62 201

Registrar
DHMH 17 Rev 7/2009

State

SUITE 210, LUTHERVILLE, MD

21093

2360 W JOPPA RD,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

HOLLY R. DAHLMAN,

. Date filed (Month, Day, Year)

JUN 0 8 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #2perphy 9916, 6/2//11 d.o. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death /29/2011 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 11.00PM VIDZEL TOWIR Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Randallstown Northwest Seasons 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days Hours Min 1012041933 N. Courtarolina 213-30-3654 77 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No MD N/ABaltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21215 U.S.A. 5324 Cuthbert Ave. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Beth Steel 8th Grade Steel Worker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve ဂ Callie Ovella Moore Mozel Blakney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5324 Cuthbert Ave., Baltimore, MD 21215 Annie M. Howie(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🔀 Cremation 3 🗍 Removal from State on-site Crematory 06/02/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between ATHEROSCIEROTIC CEREBREVASCULAR nset and Death Immediate Cause (Final ISEA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death ned by the a 9 Unknown 9 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? certificate al No Yes 2 No 1 Yes ient Da 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this To the Funeral Director: Atter the completed filled in by the funeral 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 282 30/11 mi Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH AVE, BALTO 2835 I AZNEEM 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JUN 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per Phy g916,6-8-2011 do State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:29 PM June 5 Day 20 1 Year Physician/ raram Medical 4a. Facility Name (if not inet court **Examiner** ounty of Death Eldersburg 1851 Statford arrol 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year If Under 24 Hr Funeral 8. Date of Birth 38-9620 5 Pay 928 1 □ M 2 ₩ Director or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21216 items 23a Funeral 2703 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces 1 Never Married 2 Married "natural", or Completed by 1 Yes If Yes, Give 2**)** lo 1 Tyes 2 No Specify. 3 XWidowed 4 ☐ Divorced Year or Dates 72 hours Maryland 21215-00 other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Typ. DO NOT use retired)

Work 15. Decedent's Education (Specify only highest grade completed) marked other than Layertment of Health and Mental Hygiene. Important: If item 27 is marked other in viriuny or other tremmen //Secondary 2+h College (1-4 or 5+) Be Father's Name (First, Middle, Last) Bowens lashington 19a. Informant's Name/Relationship (Type, Fritterand Sun) Town, State, Zip Code) 19b. Mailing Address (Street Eldersburg, MD 21784 Hndre Ingram altímore, 20b. Place of Disposition (Name of cemetery, crematory or other Baltimore Nat 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bultimore, InD 10-11 National any injury once, 4 Donation 5 Other (Specify) Greene Funeral
Li Mational Pike 21. Sign to e of Funeral Service Licensee l Services 23a. Part 1. Enter hadisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 12/229 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): 10 Medical Examiner Lovenury Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month the q 🗍 Unknown 9 Unknown I signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2XNo 1 Yes 3 Probably 4 Unknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perform this certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? grandson home Other: 4 Nursing Home 5 ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1.XNatural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one 29b. Signatur 29d. Date signed (Month, Day, Year) 1743386 6.6.11 14.1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO. Ballinor Daniel 12. 1714 Mace lfoward 2/2/7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5taerof Mas Aard & Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Physician/ Ohnson 09:30 PM enue 1011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Loch Raven Baltimore 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Davs Hours 978 93 9ar) 51 Director items 23a or 28a-f show ner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21227 2016 Northeast Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12 Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important. If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner. Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Hazardous Waste</u> ahorer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tina Smith Johnnie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2016 Northeast Avenue Baltimore, MD 21227 Padwa Johnson/brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or once. Crownsville Cem. 6/9/2011 Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licen 22. Name and Address of Facility 4300 Wabash Avenue Baltimore, MD 21215 March FH West Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arcinous disease or condition resulting in death) **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown the 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 PNo 1 ☐ Yes 2 🔀 No I Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 XNo ုင 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 2 Accident
3 Suic s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 1 Precritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. **To the F** omec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhinace no 21218 900 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Johnson Physician/ Month Jannie 5:02PM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore 3652 Campfield Road Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 😿 F Months Days Country) 99 212-14-2267 1912 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified 1 Yes 2 No Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3652 Campfield Road 21207 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 **X** No If Yes, Give Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced Year or Dates and Mental Hygiene.

is marked other than "natur raumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 4th House Wife Home permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tr</u> once, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Mary Goodwin 2 Dennis Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3652 Campfield Road Balto., MD Patricia Davis - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 1 Donation 5 ☐ Other (Specify) 6/9/2011 Balto. Balto., MD National Signatur of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave. March Funeral Home West, Inc. Balto., MD 21215 23a. Pait 1. Enter the disease, or complications that caused shock, or heart airre. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Parkinsons Onset and Death End-Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter or derlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Yes signed by the a d be detached f Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed. Yes 2 No 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 V No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) n3 Rujapahse M.D D0057465 6/7/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD N. S. Rajapa Kse, M. D. 5-703 2835 Smith State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pay 2011 Fannie Elizabeth Johnson 6:45 a M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA 4907 Litchfield Baltimore Avenue 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months 1 M 2 X F 215-12-1167 90 Dec 10 1920 Yrs **Director** MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f Baltimore MD NA 1 X Yes 2 No 10e Street and Number 9 10f. Zip Code 10g. Citizen of What Country? pe ms 23a Funeral 4907 Litchfield 21215 Avenue USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2X No Specify: "natural", 3 Widowed 4 X Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) NA Domestic Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental F 27 is marked of traumatic even မ Bertha Smart Charles Meyers 1 and 2 should be of Health and Meritem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Elliott - Daughter 21239 1246 Rossiter Ave. Apt. 3A Balto. MD other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite 1 🙀 Burlal 2 🗆 Cremation 3 🗆 Removal from State Important: If is any injury or o cemetery, crematory or other place) Woodlawn Cemetery | 6/11/2011 Baltimore, MD Donation 5 Other (Specify) Signatire of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave. 13. March Funeral Home West, Inc. Balto. MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 66 disease or condition Medical resulting In death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence on attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for 5 Other (specify) Month Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? Yes 2 death? this certificate Yes 2 No • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work Investigation 1 Tes 2 🗌 No completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date, signed (Month, Day, Year, of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Klima 5:40 A M June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Dundalk Genesis Eldercare - Heritage Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 **X** M 2 □ F 1917 Maryland 94 Director 212-07-2107 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 2048 Kelmore Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MTA Mechanic / Driver 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Madeline Deveo John Klima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2017 Kelmore Road, Dundalk, Maryland Daughter Lois Byrne Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June Bate 1 Durial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 2011 Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Sen 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final CH CARDIO Physician/ disease or condition Medical resulting in death) Examiner 0 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 9 Unknown 2 No the 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page perform 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify, 27. Manny of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident Investigation the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be within 24 hours after dear to the Funeral Director completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 10eath (Item 73a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

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**ORIGINAL** 

John Kelly 11-04093 UNK UNK

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State of Marvland / Department of Health and Mental Hygiene

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	Σ	29b. Signature and t	title of certifier	/				nse number C.M.E.		June 1, 201		, Day, Year)
	-	30. Name and addre	ess of person wh	o completed cause o	f death (Item	1 23a)				, = 5		
₹∧		Pamela E. S	· ·				W. Baltimo	ore Street, Ba	altimore, MD 2	1223		
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Koczorowski Michael 6 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Rose dale mose Square Franklin 8. Date of Birth If Under 1 Year If Under 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 6. Sex Funeral Days Min. Sept 17 , 1925 Months Hours Maryland 85 220-14-4914 Director Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Dundalk Md. Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21222 U.S.A. 2493 Fairway 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Carpenter 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ဂ Catherine Szyumska Michael Koczorowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2493 Fairway Baltimore, Maryland 21222 Margaret Koczorowski/wife 20b. Place of Disposition (Name of JuneDate 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Holy Rosary Cem. 7, 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Icens e 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore. Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner COL attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death been signed by the should be detached if 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 2 No cate has by page 2 s death? 1 Yes 2 No After this certificate 25. Was case referred to medical examiner?
1 □ Yes 2 ▼No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Res 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 7/2009

m Chae

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 11:13AM League JUN Medical 0 O II 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Baltimore Halbor 2 MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 1, 1923 6 Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 1 M 2 W F Director MD 214-40-0790 87 Usual Residence of Decedent ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2xx No MD Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 1607 Marley Ave. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XXVo Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Specify: White "natural" 3XX Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elsie Foreman John T. Greenwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Marley Ave., Glen Burnie, MD 21061 Joseph D. League Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State XXurial 2 Cremation 3 Removal from State Glen Haven Cemetery June 10, 2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Fink Funeral Home, P.A. Licegory Eick 426 Crain Hwy S., Glen Burnie, MD 21061 Part . Enter the disease, or shock, or heart failure. List o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ congestive Heart Failule Medical Due to (or as a consequence of) Examiner Esqueritiany not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and Failure Rona the burial-trans signed by the attending physician and d be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Year 5 Other (specify) Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an autopsy performed' 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examine ? Other: 2 🗌 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Tes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining Priyaction: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier Pantea Hashemi RES OO 1 June 05 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 3001 S Pantea Hashemi Hanoverst, Baltimore, MD 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 03 Day 06<sup>Month</sup> Physician/ 2011 Robert George McEvoy 4:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pasadena 8457 Main Avenue Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours Country) 1 🔀 M 2 🗆 F 017024 Director 216 42 4474 69 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 1 Yes 2 X No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8457 Main Ave 21122 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced White Year or Dates er than "natura", the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) and Mental Hyglene. is marked other tha Engineer Tech US Coast Guard Mechanical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles McEvoy, Sr. Alice Marie Hoppe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Robert McEvoy, Jr. - Son 1912 Willow Spring Rd Dundalk, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/7/2011 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, MD 21. Signature of Funeral Sovice Lion see 22. Name and Address of Facility GJ Gonce Funeral Home, Riviera Drive Pasadena, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live Birth 2 Live Birth 4 Pregnant at time of death in the past 12 months? Day Vear 2 No been signed by the should be detached g Unknown a 🗌 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 □ Unknown 1 Yes 2 No Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 1 🗌 Yes 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide termined City or Town, State) within 24 hours a To the Funeral D Medical rtifying mys cia: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Me of Chamic n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certi, me Note stationer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

d title of deather. 29a. Certifier 29b. Signature and title of g 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person d cause of death (Item 23a) (Type, Print) alen SILCAJIS State 8 Registrar

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	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 herurs after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2 Medical I only one) 3 Certifying	g Nurse Practioner:	sis of examination	n and/or inves	stigation, in my opini	ion, death occurred	at the time, date	and place, and d	lue to the ca	use(s) and manner stated.
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5			30. Name and address of person	who completed caus	se of death (Item 2735 Sr	n 23a) (Type, I	Print) 5 - 7	1.03 Ba	Itimore	MO	212	209
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	Funeral Director		Social Security Number     197-09-1969     □ M 2      □ F  Usual Residence of Decedent	1 M 2 W 5 Q 8 Months Days Hours Min. (Month Day Year)								
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Baltimore,	permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.	- 8	20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State ceme	etery, crem	sition (Name of latory or other place n Cemeter	:e)					
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	To the within ? To the comple	Ž	only one) 3 Certifying Nurse Praction f.  29b. Signature and title of certifier	to the best of my known	owledge, d	leath occurred at th		1	ause(s) and mann d. Date signed (A			
<b>)</b>			30. Name and address of person who completed caus	e of death (Item 23a	a) (Type, P	rint) Mcc	Ison Par	K Don	6 6	len Burhierria		
	Sta	te	31. Date filed (Month, Day, Year) 32 R	egistrar's Signature	40	1	,	, , , , ,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Gilbert Oechsler 6:50p M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care North Point Dundalk 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year I If Under 24 Hrs . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 52 M 2 □ F 213-34-1967 75 Director Marvland November 13,1935 Usual Residence of Decedent 28a-f show 10b. County 10a. State with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral Apt. 608 101 Center Place 21222 USA items permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked 6 years N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elmer Carl Oechsler Anna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joreatha Oechsler Niece 8006 Wallace Road, Dundalk, Md. 21222 20b. Place of Disposition (Name of 20a, Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or June 6, Bayview Crematory 2011 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 3a. Part 1 Enter the disease k, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by 1 page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 2 1 10 1 Ves 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death Check only one) Be Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 No n 24 hours after death te Funeral Director: A pleted filled in by the fu Investigation 1 Yes Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only on 29b. Signa 29d. Date signed (Month. Day. Year)

State Registrar wortham woods load mD 21234

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ TUNE 2:27 PM Medical 1b City, Town, or Location of Death 4a. Facility Name (if not institution for estreet and number) Examiner County of Deat Koad tone Deverna If Under 1 Year If Under 24 Hrs Funeral 9. Birthplace (State or Foreign Date of Birth 218-28-1486 1 **№**M 2 🗆 F Months Days Hours Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State City, Town or Location 10d, Inside City Limits Director everna 1 🗌 Yes 2 🛂 o 10f Zin Code 10g. Citizen of What Country? Funeral 2114 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status or p Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: 3 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) on ay (0-12) College (1-4 or 5+) elde Be ပ Health attem 27 i hirley Deverna 20b. Place of Disposition (Name of cemberry, drematory or giver place) 20a. Method of Disposition Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6-11-2011 4 Donation 5 Other (Specify) 21. Signature of Funera Service Licensee Greene Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): death certificate be executed physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: nse s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5  $\square$  Pending work? within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident 1 Tes 2 🗌 No Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expinier: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Jurse Practioner 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 KWOLL NORTH Dr. #140 5450 <u>M4</u> samon State Registrar

68760

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death EMILIA S. PLECKER Physician/ JUNE 2014 9:05 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST CENTER TOWSON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min 1 M 2 Tx 10/29/1917 214-14-3466 Yrs. Director 93 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE LUTHERVILLE 10e, Street and Number 10g. Citizen of What Country? Funeral 21093 USA 119 CHARMUTH ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 □ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important; If item 27 is marked other th, any injury or other transmant. DENTIAL ASSISTANT DENTISTRY 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THERESA VELME JOHN SILVERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FERN P. MORRISON/DAUGHTER 119 CHARMUTH ROAD LUTHERVILLE, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/6/2011 METRO CREMATORY. INC: CATONSVILLE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MO0217 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chemi disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consumence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 20 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner's Hospital Other: 2 1 Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) WW YOU 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending М 1 Yes 2 No Investigation Accident completed filled in by the ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 2 201 and address of person who completed cause of death (Item 23a) (Type, Print) CHANCES TOW NO WAS MM 670 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 7/2009 JUN 0 8 2011

Box 68760

P.0.

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Physician/ Year 00 Willard Post 2011 6 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore FRANKLIN Square HOSPITal Center Rosedale If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral 1 🔀 M 2 🗆 F Hours Min (Month, Day, Year) Director 212-36-5452 72 April 22. 1939 West Viminia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits death with the Maryland Director must be notified Baltimore Dundalk 28a-f MJ. 1 Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a21222 USA 3124 Cornwall Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give and 2 should be filed within 72 hours after thealth and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Foreman <u>12 years</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Willard W. Post Pauline Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 3124 Cornwall Road, Dundalk, Md. 21222 Wife Beverly Post 20a. Method of Disposition 20b. Place of Disposition (Name of June 9, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Lakeview Memorial Randallstown, Md. 2011 21. Six ature of Fineral Service License Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Hepatorenal Syndrome week disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** LIVER CITCHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Hepatic encephalopath that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical unknown Non Small cell Luna Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year signed by the a a \ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by metastatic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy this certificate har ral director, page 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this of in by the funeral din 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Zhang, MD Yuling D70605 06/06 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4000 FRANKLIN Square DR Balto md Day, Year) State JUN 0 8 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Borr Pens 1158 M Medical 2011 June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Randallstons Baltimore Northwes Hospital yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F Months (Month, Day, Year) 11/28/1922 Hours Min. 109-74-9708 Director 88 Yrs UKRAINE, RUSSIA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3615 FORDS LANE, #615 21215 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Je filed with. \*∗al Hygiene. \* or than "r 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) MANAGER 4 YRS. RAILROADS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, ပ SRIII. PENS HAYA and 2 should be Health and Metern 27 is mark and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VLADIMIR PENS/SON 2820 QUARRY HEIGHTS WAY, BALTIMORE, MD 21209 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Plage of Disposition (Vame of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHIZUK AMUNO 06/05/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass Le 8900 REISTERSTOWN ROAD, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? ☐ Ectopic pregnancy jo Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 KN page 2 certificate 1 Yes 2 K No Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After Hospital or Attending Matural Natural 5 Pending work? hin 24 hours after death. the Funeral Director: A mpleted filled in by the fu death. Accident Investigation 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

State Registrar

P.O.

5401 OL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

JUN 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Edward Petkus May 31  $P^{M}$ 7:17 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Care Center Baltimore Towson Social Security Number 8. Date of Birth (Month, Day, July 27 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 XM 2 🗆 F Months Hours Director 214-18-5189 88 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified as once. 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Md. Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12261 Roundwood Road Apt 1515 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 H Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Route Self-employed Driver Be 17. Father's Name (First, Middle, Last)
Felix A. Pe 18. Mother's Name (First, Middle, Maiden Surname)
Anna Mylash ၉ Α. Petkus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Suter / Daughter 8800 Walter Blvd.Apt 4112 Parkville,Md21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State  $Jun^{\text{Bate}}$ Burial 2 Cremation 3 Removal from State Holy Rosary Cem. 4 ☐ Donation 5 ☐ Other (Specify) 7,2011 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facilit Kaczorowski Funeral Home, P.A 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ auchentic disease or condition Medical resulting in death) de to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Lines Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? fo Month Pregnant at time of death 5 Other (specify) Day Year detached g Unknown g Unknown ģ cate has been signed I page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has leampleted filled in by the funeral director, page 2 s autopsy perform 1 ☐ Yes 2 🔊 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 定 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINSON MO 31. Date filed (Month, Day, Year)
JUN 0 8 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 11:30 PM **Physician** omoser 1008 201 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Heritage Harbor Health & Rehabilitation Cente Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number Months Days **Funeral** Hours 1□M **¾**□F December 22, 1917 Maryland 93 Director 220-38-8296 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 Funeral 2700 S Haven Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 2 No 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Maryland 21215-0036 Specify hite 2 3 ☐ Widowed ♣️ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) Shoes Sales 12 12 should be filed whand Mental Hygien 7 is marked other to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If frem 27 is marked oil any Injury or other traumatin Be Madelin A. Laib Robert A. Ramming ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1867 Burley Road Annapolis, MD 21409 Romoser Son Albert Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jun 07 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility vice Licens 21. Signature of Funeral Ser Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena Maryland 21122 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line.  $\emph{t}$ Approximate Interval Between Onset and Death e, or complicat List only one 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final 0 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 1ei Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed DEX physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 🗌 Inpatient 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mann Death 28b. Time of 28c. Injury at Work? After t Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1AHBOOB E

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20<sup>Year</sup>1 CATHERINE E. SEETS JUNE 6 6:22 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 M 2 XF 6474374923 MARYLAND 216-14-0404 87 **Director** Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 🗌 Yes 2 🗓 No MD BALTIMORE TOWSON 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral items 23a 21204 615 CHESTNUT AVENUE APT. 1406 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE "natural", 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COSMETIC MANUFACTURING SECRETARY 12TH GRADE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ EDNA HILGARTNER GEORGE WAGNER Page 1 and 2 should be other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i BALTIMORE, MD 21234 8331 HILLENDALE RD. KAREN E. SEETS/DAUGHTER timore, 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 9 Department Important: II 6/8/2011 CATONSVILLE, MD METRO CREMATORY, INC. injury 4 Donation 5 Other (Specify) permit. 22. Name and Address of FacilINE JOHNSON FUNERAL HOME, P.A. . Signatur of Funeral Service Licensee MO1139 8521 LOCH RAVEN BLVD. TOWSON, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (c Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Month the 9 Unknow signed by Part II. Other sing ficant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 Probably 4 Unknown 1 Yes Completed been a 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 certificate or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Certificate: To this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 (Month, Day, Year) iniun 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) D0066584 7/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRAMSANIA CHARLES 57 Towson, MO 6701 N. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

Registrar

JUN 0 8 2011

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

amonte Sherma	1	State of Maryland - For State egistrar		tificate of				Reg.	No.		10101
Physicia Medical Examir	n/	I. Decedent's Name (First, Middle,Last)  Lamonte Tracy Sherman	n				l N	Date of Death Month D lay 29, 201	ay Ye		3. Time of Death 2321 hrs
neulcai Examin		4a. Facility Name (if not institution, give street and number		4	b. City, To	wn, or Location of		14, 20, 20.	4c. County		
		Baltimore Washington Medical Center			Glen E		72	- 25.0	Anne A		nless (State or
Funeral Director		5. Social Security Number 6. Sex 7. A 217-84-6859 1X M 2 F	ge (In yrs. ta 3 9	ast birthday) Yrs.	If Under Months			3/3/1		Foreign Cour	place (State or ntry) MD
Rus	-	Usual Residence of Decedent  10a. State  10b. County	10c. City,	Town or Location	on					T	10d. Inside City Limits
		MD Harford	Abe	erdeen							1 Yes 2 X No
Maryland 28a-f show	Director	10e. Street and Number			10f. Zip (	Code		10g	Citizen of V	/hat Count	ry?
3a or		307 Stevens Circle Ap	t. 2	C	210		1010 - 1	No salla	USA	a Amorio	an Indian, Black,
th with	Funeral	11. Marital Status  1 X Never Married 2 Married Armed Forces	?	S. 13. Was	Deceder s, specify	t of Hispanic Orig Cuban, Mexican	gin? (Specif , Puerto Rica	y Yes or No- an, etc.)		te, etc.	an indian, black,
ter dea		1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	X No	1	Yes 2	No specify:			Specify.	blac	ck
ours aff	d b	15. Decedent's Education (Specify only highest grade co	mpleted)	16a. Decedent	's Usual C	ccupation (Give	kind of work	done 1	6b. Kind of E	lusiness/In	dustry
11 21 5-0036 It be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	sale		J	,		Car 1	Deal	ership
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	BeC	Larry Wilson						ne She			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28s-f she natic event, the Medical Examiner must be notified at once	흔	19a. Informant's Name/Relationship (Type, Print)	. 1	19b. Mailing 5323		(Street and Nur		Route Number mbia,			Zip Code)
Md 2 alth na 2 aug	-	Ernestine Sherman/mot	20b. F	Place of Disposi	tion (Nam				20c. Location		own, State
Baltimore, Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from S		crematory or oth	er place)		6/9/	2011	Balt	imor	e, MD
Itim iit. Pa		4 Donation 5 Other Specify:	- Inc		_	Address of Facilit	_	00 Wak			
Deput Deput		Servara C. Serva	NH.	Ma	rch	FH Wes	Ba.	ltimor	ce, M	D 2	1215
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/Medical xaminer	Y	parmediate Cause (Final disease or condition resulting in death)  a. Multiple Sharp  Due to (or as a condition)									5041
· · ·		Sequentially list conditions, b.	30querioc o								
	ner	if any, leading to immediate Due to (or as a concause Enter Underlying Cause	sequence o	of):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	sequence o	of):							
( <b>0,</b> e be executed ysician and burial - transit	<u>a</u>	d									
e be ex ysician burial	ledical	UNPENDED AMENDED	of oron						23d. Date	of delivery	
876 tificate ng phy as the	M/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome the past 12 months?	ome or preg		tal death	3 Ectop	ic pregnancy	,	Month		ay Year
Box 6876  death certificate the attending phy ed for use as the b	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	at time of de	eath 5 Ot	her (Spec	ify)					
D. B.	Phy	Part II. Other significant conditions contributing to de	ath but not r	esulting in the u	ınderlying	cause given in P	art I.				the cause of death?
, P.O. res that the signed by be detac	d by							1 Yes	2 <b>N</b> o		
Division of Vital Records, ral or Attending Physician: The law requirers after death.  **I Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed							24a. Was ar autops	4	prior to c	topsy findings available ompletion of cause of
Reco The law cate has	omo							perform 1 Yes 2		death? 1 ✔ Ye	s 2 No
tal Rec eian: The certificate ector, page	BeC	25. Was case referred to medical examiner? Hospital: 1 Inpa				26. Place of Death		y one) Iome 5 F	: G	Clothor	
f Vit	ဥ	1 Yes 2 No		ER/Outpatient		OA Other 4 L		d. Describe ho			
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risic r Atter ter dea irector n by th	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	Injury - At h	nome, farm, stre	et, factory	office building,	etc. 28	or Town, Sta		nber or Ru	ral Route Number, City
Div pital o	Certification:	4 Homicide determined (Specify)		id / Highway				18 Ritchie H	ighway, Gle		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of e	my knowled	dge, death occu and/or investiga	rred at the tion, in my	time, date and propinion, death of	lace, and du occurred at th	e to the cause ne time, date a	(s) and man nd place, an	ner as state d due to th	ed e cause(s)
To the Ho within 24 To the Fu	Medical	one) 2 Medical Examiner: On the basis of e and manner state  29b. Signature and title of certifier.		018		. License numbe					nth, Day, Year)
	_	With I have been	113	180		O.C.M.E.			May 30,	2011	
		30. Name and address of person who completed cause of				-	5 10	ND 0100	^		
		Victor Weedn MD JD Assistant Medic				nore Street,	Baltimore	, MD 2122	3		
S Regis	tate	31. Date filed (Month, Day, Year) 32 Regis	trar's Signat	1 hou	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #195 Per FH C916 /6/08/2011 JH Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SHAPIRO 9.05AM SARRA Physician/ 121112 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER Birthplace (State or Foreign Country)
 TIVE A TAKE If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** 1 🗆 M 2 🔀 I Davs Hours 0870571905 UKRAINE 105 Director 217-37-2189 Usual Residence of Decedent Show 10d. Inside City Limits or 28a-f shov notified at 10c. City, Town or Location 10b. County death with the Maryland Completed by Funeral Director 1 🗆 Yes 2X No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. 21215 1 AMLEHT COURT, APT. 1A USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT GENERAL WORKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည UNKNOWN UNKNOWN ZENOVIY GANKIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) COURT, #1A, BALTIMORE, MD 21215 DMITRY SMOLKIN/GRANDSON 20b. Place of Disposition (Name of 20a Method of Disposition cemetery crematory or other place. ARL INGTON CHIZUK AMUNO CEMETERY 1 XBurial 2 Cremation 3 Removal from State BALTIMORE, MD 06/05/2011 4 ☐ Donatiop 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of uneral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIMER & DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ending physician are as the burial Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
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Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Medical Examiner: On the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29d. Date signed (Month, Day, Year)
TUNE 3 2011 29c. License number 1) 5 4 2 8 8 ame and address of person who completed cause of death (Item 23a) (Type, Print) HUSP ITAL COMTOR NOOPH WEST State IUN O 8

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04 p JUNE 2011 2:44 PM MARLYN SHANHOLTZ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 650 OWINGS MILLS BALTIMORE 4730 ATRIUM COURT, APT. 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 24 Hrs If Linder 1 Year 8. Date of Birth . Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗓 F Hours 08/14/1922 Yrs Director 88 PA 180-12-6419 Usual Residence of Deceden ms 23a or 28a-f show must be notified at ige 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene. It file me 72 is marked other than "natural", or items 23a or 28a-f sho or or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 4730 ATRIUM COURT, APT. 650 21117 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) **SECRETARY** ACCOUNTING OFFICE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ LOUIS LAZAR REBA SILVERSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARL SHANHOLTZ/SON 3 EMERALD RIDGE COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 KBurial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) MONTEFIORE CEMETERY 06/07/2011 JENKINTOWN, PA Signature of uneral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Approximate Interval Betweer Onset and Death Immediate Cause (Final Ph sician/ disease or condition LOTIGOTIVE don Medical resulting in death) Due to (or v a consequence of): Examiner warmy Sequentially list conditions, Examine Due to (or as a consequence of): if ally, leading to immediate cause. Enter Underlying or Attending Physician; The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo Month Day Year Pregnant at time of death 5 Other (specify) No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dementos 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 🗖 🗛 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 10 2 7 No Other: 1 Tes 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA this the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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JUN 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# I 8 per FH, G916, 6/24/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 191 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:18P M 2011 Saucier 06 Dorotha L. June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Walkersville Glade Vallev Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 1 M 2 XF 224-34-0207 North Carolina Yrs 1932 Director 78 Usual Residence of Decedent 28a-f shov 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director or than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD. Carroll Mt. Airy 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** USA 21771 3297 Stuart Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 1 and 2 should be filed within 7/3 fealth and Mental Hygiene. item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Govt. Clerical permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be With Matter's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Stewart Robert Hough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrienne Saucier Stup/ Dtr. 3297 Stuart Drive Mt. Airy, MD. 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-10-11 Timonium, MD Oulanev Vallev Mem. 21. Signature of Juneral Service Lice and Address of Facility
Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on paginine. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to Exami the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury 1 X Natural 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) within To the 29b. Signat re and title of certifier License number 29d Date signed (Month, Day, Year) JUNE who completed cause of death 32. Registrar's Signature State 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2011 Betty Beatrice Thompson 930 PM UNE /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year Social Security Numb . Age (In yrs. last birthday) If Unde Date of Birth (Month, Day, 9. Birthplace Country) **Funeral** Months Days 1 □ M 2 🛱 F Hours Director 226-40-2626 1936 Virginia 2, Apr. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Pleasant Lane 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 □Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 ☐Yes 2√☐No Þ Specify: Specify 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph (nmn) Woolwine Stella (nmn) Lawson nd 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry N. Thompson/Son 400 Pleasant La., Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baker's Cemetery 6-6-2011 Aberdeen, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Lowin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to or as a consequence of . The law requires that the death certificate be executed physician and s the burial-transit Exami Due to (or as a consequence of) Box 68760 Physician/Medical attending pt for use as the IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 1 ☐ Yes 2 ☐ No 9 Unknown as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3☐ Probably 4☐ Unknown Completed 1 ☐ Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Yes 2 Wo page 2 □No or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □ Yes 2 Accident 24 hours after death Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the Partition 24 and manner stated. 29b. Signature and title of certifier 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 0 u 31. Date filed (Man State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician/ June 5, 2011 10:10 a M Jane G. Veiga Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Alabama Days Hours Aug 24, Year 929 1 M 2 7 F 81 578-44-3721 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 X No Towson Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21286 800 Southerly Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 X Widowed 4 □ Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Special Education Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Laura Jane Butler William C. Gillespie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1409 Bankert Terrace; Abingdon, MD 21009 J. Vincent Veiga, III / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 4 Donation 5 Cremation 3 Removal from State Timonium, MD Dulaney Valley Mem Gardens: 6/8/2011 1050 York Road 22. Name and Address of Facility 21. Signature of F Towson, MD 21204 Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Phylician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Physician/Medical Examiner Due to for as a consequence of; that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YPERTENSION 1 Yes 2 No 3 Probably 4 Inknown Certificate: To Be Completed ORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Other (Spe 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Clerifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific (Month, Day, JUN 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State SHMa69and 6698annent of Health and Mental Hygiene For State Registrar Certificate of Death Charles Randolph Watts, JR. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 8.30 AM 05 201 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** PRINCE GEORGES Regional Birthplace (State or Foreign Country) 8. Date of Birth If Under 1 Year If Under 24 Hrs. last birthday cial Security Number **Funeral** (Month, Day, Year) Days Hours Min. 1**X** M 2 □ F Months 219-38-4993 Director Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Laurel Prince Geroges MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 20723 10095 Washington Blvd N #213 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2x No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16b. Kind of Business Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Self Employed 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Esther Williams 2 Charles R. Watts Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 84101, San Diego, CA 92138 Sheila R. Watts-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 6/3/2011 Woodlawn, Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ediate Cause (Final Resprotor Physician/ disease or condition Medical resulting in death) Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death Month Day in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed 2 星 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. Investigation Accident within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗍 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 05. 30.20 11 068782 M·D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04112 State of Maryland / Department of Health and Mental Hygiene Sheldon Walker Certificate of Death 1- For State Reg. No Registrar 2 Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 1733 hrs June 1, 2011 **Medical Examiner** Walker Sheldon 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Country) MD 26 215-08-1772 Director Mar.14,1985 1 M 2 F Yrs. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore MD 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21206 4602 Furley Ave. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X No Yes Specify: Black If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed 4 Divorced 5 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Triumvirate Enviro Elementary/Secondary (0-12) College (1-4 or 5+) mental 12th Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patsy Moore Anthony Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4602 Furley Ave. Balto, Md. 21206 (mother) Patsy Moore Date 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 9 crematory or other place) June 1 X Burial 2 Cremation 3 Removal from State ValleyCem. 2011 Baltimore, MD Dulaney Donation 5 Other Specify 22 Name and Address of Facility Calvin B. Scruggs Funeral Home Signature of Funeral Service Licenses Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED attending physician or use as the burial UNPENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> О 1 Yes 2 No 3 Probably 4 Unknown <u>چ</u> Completed Records, 24b. Were autopsy findings available has been s 2 should t 24a Was an prior to completion of cause of autopsy performed? Yes 2 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> examiner? Hospital: 1 ✔ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: this 1 Yes No 28d Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject Driver of pickup truck that struck a pole Jun 1, 2011 within 24 hours after oca...

To the Funeral Director: A Natural 1142 hrs 1 ✓ Yes 2 No Pendina 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) Dulaney Valley Road & Meadowcroft Court, Towson, MD (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number (9 June 2, 2011 O.C.M.E.

Victor Weedn MD JD

State
31. Date filed (Month, Day, Year)

Registrar

JUN 0 8 2011

32. Registrar's Signature

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month Year Physician/ 3:15 A M Wilson Samuel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Seasons Hospice @Northwest Hospital Randallstown 6. Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours Min. (Month, Day, Year) Apr 18, 1947 Months VΔ 216-42-6798 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Markinal Freeze. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Gwynn Oak MD **Baltimore** 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21207 5322 Dogwood Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Carpenter (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry / Building Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donie Ethel Ruhamma Willis ဂ William Alfred Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Twin Mountain Lane Hedgesville, WV 25427 19a. Informant's Name/Relationship (Type, Print) William H. Wilson Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Removal from State cemetery, crematory or other place)
Good Shepherd Cemetery Jun 08, 2011 Ellicott City, Maryland nation 5 Other (Specify) 22. Name Sidok Füßer all Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Sian neral Service moos Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Onset and Death mediate Cause (Final Physician/ cancer Lung disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if dry, reading to trained attended cause. Enter Underlying Examiner Duri to for an a nonnections: off sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death detached Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed has 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) City or Town, State)

eral Director: After filled in by the funer within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MSRWAPANNEMID D0057465 613/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2/209 5-203 · S · Rajapakse /MID 2835 Smin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar M DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:15 PM 2011 Frances Bernice Wright JUNE Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes Hospital BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. g, Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** 1 🗆 M 2 🄀 F Hours Min. 0 6 gay Year 934 Maryland 76 219-28-6689 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notified at 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Gwynn Oak Baltimore MD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 3531 Flannery Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: ed other than "natural", event, the Medical Exa 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Waverly Press Inc. Administrative Tech. 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melinda Parker permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic Joseph M. Booker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 N. Washington St., Baltimore, MD 21213 Curtis Washington Sr.(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Baltimore, MD on-site Crematory 06/13/11 For Britown Jr. Funeral Home 21. Signature of Funeral Service Licenses 2140 N. Fulton Ave., Baltimore, MD 21217 learns Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE RENAL FAZLURE 1 Yes 2 No 3 Probably Winknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Severe Cardiomyopath performed 1 ☐ Yes 2 ☐ No After this certificate of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation s after deat 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06/02/2041 25924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S CATION AVENUE, BALTIMORE, MD 21229 NIRAV PATEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1255 PM Wils on 2011 Januel ma Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon secour Hospital Baltimore 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral 04/24/ Country) Carolina 1 🔀 M 2 🗆 F Months 247-58-3354 76 Director 1935 ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Baltimore 1 Yes 2 No MD N/A 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 303 S.. Funeral Pulaski St. 21223 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16chiesapeakery Site (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 6th Grade (0-12) College (1-4 or 5+) Heavy Equipment Operator Contracting INC. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie Hugee Harvey Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Walton(friend) 303 St., Baltimore, Pulaski MD 21223 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 😾 Burial 2 □ Cremation 3 □ Removal from State Harvey& Jame Mem. 06/07/11 Salters, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Josephod H. of Brown Jr. Funeral Home Baltimore, M Fulton Ave., N. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betweer shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iiniury sician and bunial-trans that initiated events resulting in death) Last the attending physician Physician/Medical The law requires that the death certificate be Box 68760 as the IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No detached for Day 5 Other (specify) Pregnant at time of death Unknown P.O. signed by Part II**, Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy 2 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes Division of Vital Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case refered t 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) W. Baltimore. 2000 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

JUN 0 8 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 31Day 20°4"1 05nth 4:45р м Physician/ Arlethea Young Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Manor Care Health 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) **Funeral** Virginia 1 □ M 2🛣 F 07/257/1924 219-14-2200 Yrs Director 86 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Directo Windsor Mill 1 Yes 2 No Baltimore Co. MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Funeral 21244 1525 Rolling Road death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Yes 2 No If Yes, Give 1 Never Married 2 Married should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Frances Scott Key event, the LPN 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Thompson Robert Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD , 21244 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7874 Corner Stone Way Unit 7, Windsor Mill Gail Jett(daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 Fernation 3 Removal from State Baltimore, MD on-site Crematory 06/03/11 4 Donation 5 Other (Specify) 21. Sign and f Funeral Service License Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final METASTATIC GASTRIC CARCINOMA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner seque tian, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Ves 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 U Yes 2 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has ☐ Yes 2 ☐ No Yes 2 X N certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပု After this 28b. Time of funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 28d. Describe how injury occurred Medical Certificate: Natural Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 CENTER DRIVE UMA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2011

		4	Ple	<b>ase Type or</b> State o		nd / Dep	artment o	f H	ealth		_		_	ible.	
	Dhysisis	,	Registrar  1. Decedent's Name (First, Midd	le, Last)		Ce	rtificate o	t D	eath		2. Date of D		Tree (s)	Your	3. Time of Death
	Physicia Medic Examir	al .	Rosalie M.  4a. Facility Name (if not institutio	4b. City, Town	n or l	ocation	of Death	June	3°		)ÎÎ	5:35 Рм			
-	Examil	0.	Stella Maris	Hospice			Tim	on	ium			]	4c. County of Death Baltimore		
	Funeral Director		5. Social Security Number 217–12–0678	6. Sex 1  M 2 <b>X</b> F		. last birthday) 88 Yrs.	If Under 1 Ye Months Da		If Under Hours	24 Hrs. Min.	8. Date of B	irth 124 <sup>Year)</sup>	1923	9. Birthp Mary	place (State or Foreign Yand
	land show dat	l h	Usual Residence of Decedent  10a. State 10b. Count	у	10c. 0	City, Town or L	ocation							1	0d. Inside City Limits
	Maryl 28a-f	Director	Maryland Balt  10e. Street and Number	imore		Towson	1								1 ☐ Yes 2 🛣 No
	death with the Maryland items 23a or 28a-f sho ier must be notified at	Funeral I		Circle A	pt. B1		10f. Zip Coo	1e L20	4			10g. C	U.S.	What Cour. $A_ullet$	ntry?
980	after or ", or camir	۵	11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 ☒ Widowed 4 ☐ Divorce	12. Was Dece Armed Fo 1  Yes	edent Ever in Urces? 2 <b>X</b> No e		Was Decedent of If Yes, specify C				cify Yes or No Rican, etc.)	)-		e - Americ k, White, Whi	etc.
15-0	72 hours aft "natural", edical Exa	Completed	(Specify only high	ent's Education nest grade completed)		(Give	edent's Usual Oc kind of work do	ne du	tion <i>inng m</i> os	t of worki	ng	16b.	Kind of B	usiness Inc	dustry
21215-0036	within glene. er thar , the N		Elementary/Seconday (0-12) 12	College (1	-4 or 5+)		naker	rea)				Ow	n Hor	ne	
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Albert Poyer	Last)					18. Moth		e (First, Middle transk		n Surname	ie)	
Maryland	nd 2 should be filed within 72 hours: salth and Mental Hygiene. n 27 is marked other than "natura er traumatic event, the Medical E.		19a. Informant's Name/Relation Phyllis Zitnik		r		ling Address (Stra Camberle							State, Zip (	
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State	cemetery, cre	position (Name of ematory or other emer Cemet	place		t 6/9/2	Oate 011	1			own, State laryland
Balt	permit. Depart Import any inj once.		21. Signature of Funeral Service	Licensee		2	22. Name and Ad 1050 Yor	dress	of Facili Road	y Ruc Tow	k Tows	on F arv1	unera and	al Ho 2 <b>1</b> 20	ome, Inc.
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	ich line.	cath. Do not en	iter the mode of o								Approximate Interval Between Onset and Death
Pay	executed an and ial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or initiary that initiated events resulting in death) Last	S c	(or as a conse										
. Box 68760	hat the death certificate beiged by the attending physicial detached for use as the bur	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No 9 □ Unknown		Birth 2 🗌 Fe	etal death 3	☐ Ectopic pregi		′					ate of delive	ery Day Year
ls, P.0	v requires that t s been signed b should be deta	ed by P	Part II. Other significant condit	tions contributing to c	leath but not r	resulting in the	underlying caus	e give	en in Part	l.					he cause of death?
Division of Vital Records,	The lavate has	Complete									24a. Wa aut per 1 🗆 Ye	s an opsy formed? s 2 <b>X</b> I		Were auto prior to co death? 1  Yes	psy findings available mpletion of cause of
Vital	/sician s certifi director	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 X No	Hospital:	Inpatient 2	☐ FR/Outpati		6. Pla Other			me 5 🗆 Re	sidence	6 <b>X</b> Oth	er (Snecifi	HOSPICE
n of	Attending Physician: ir death. ector. After this certific by the funeral director, I		27. Manner of Death 1   M Natural 5 □ Pend	28a. Date		28b. Time injury	of 28c. I	njury work?	at		28d. Describe				, 1001_101
ivisio	in <b>S</b> ite of	Certificate:	3 Suicide 6 Coul	d not be 28e. Place	of Injury - Ating, etc. (Spec	home, farm, s	treet, factory, offi	_			28f. Location City or To			er or Rura	I Route Number,
Ü	n 24 hours are Funeral I	Medical	(Check 2 Medical	ng Physician: To the b Examiner: On the bang Nurse Practioner:	sis of examinat	tion and/or inve	estigation, in my o	pinior	n, death o	ccurred at	t the time, date	and place	ce, and du	e to the ca	use(s) and manner stated
_	To the Complex		29b. Signature and title of certific	Man Ca	UNT	2	29c. Lic	ense	number	170	92	29d. C	Date signe	d (Montil),	Day, Year)
1	10		30. Name and address of person  JACKIE JONES			, , , , ,	Print)	<del>/                                    </del>	ттм/	NITIN	1, MD 2	1001	2		
	Sta Registr		31. Date filed (Month, Day, Year)			nature Fauls		•	LIFT	VIVI OF	- FID 2	.107.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jean Miller Aylor Month 2011 3:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Arbor at Baywoods Annapolis Anne Arundel Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 13 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours 579-12-3413 91 Director 1919 Washington. Usual Residence of Decedent or 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho edl-al Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Harwood 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4433 Indigo Lane 20776 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Completed by Black, White, etc. 1 Never Married 2 Married Yes 2 YNo Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give White 3 X Widowed 4 □ Divorced Year or Dates. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David Ralph Miller Ruth Louise Andreson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health a Important: If Item 27 is John R.B. Aylor/son 4433 Indigo Lane Harwood, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date XX Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 5/24/2011 Donation 5 Other (Specify) Falls Church, Virginia Signature of Funeral Service Ocense 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia days Medical resulting in death) Due to (or as a consequence of): Examiner Congestive Heart Failure weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🖾 No Month Year Day Pregnant at time of death signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law page 2 autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending injury Division n 24 hours after death.

e Funeral Director; Aft bleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D41978 May 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nader Tavakoli

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

32 Registrar's Signatur

2011

12200 Annapolis, Road, #228 Glenn Dale, Maryland

11-04073	
Walter Augustin	Ir

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	rtificate of Dea	ath	Reg	. No.	103.201
Physici Medical Exam	an/	Decedent's Name (First, Middle,Last)	AUQUSTIN	JR.		2. Date of Death Month May 31, 20	Day Year 11	3. Time of Death 1821 hrs
		4a. Facility Name (if not institution, give s Harbor Hospital	street and number)		r, Town, or Location of Dea timore	th	4c. County of Death	1
Funeral Director	1 100	NO 10 10 1	7. Age (In yrs. I		nder 1 Year If Under 24H oths Days Hours Mi		(MM/DD/YYYY) 9. Bir Foreig Co	
Varyland 28a-f show any d.at.onse.	irector	Usual Residence of Decedent  10a. State  10b. County  ANNE AR  10e. Street and Number	CNDE 10c. City	, Town or Location	IMORE Zip Code	100	ı. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23s or 28s-f sho must be notified at once	uneral Dir		12. Was Decedent Ever in U Armed Forces?		21225 dent of Hispanic Origin? (Secify Cuban, Mexican, Puerl		14. Race - Amer White, etc.	ican Indian, Black,
s after death	by Fun		1 Yes 2 No Yes, Give Year or Dates:	1 Yes	2 No specify:		Specify:	ITE
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f ahmatic event, the Medical Examiner must be notified at once	Completed	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)		al Occupation (Give kind of vorking life. DO NOT use re	etired) ER	TRUC	SIN Q
ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other ti natic event, the Med	Be	17. Father's Name (First, Middle, Last)  William WALTER	AUQUSTIN	, SR.	MADELI	ne (First, Middle, Ma NE MAR	y WAL	sh
nore, MD 2121 ages I and 2 should be fil nt of Health and Mental B it: If item 27 is marked other traumatic event,	2	19a. Informant's Name/Relationship (Typ ANNA E. AUBUSTI	. WIFE	5217 BALL	MAN AVE RA	LTIMORE	MD.ZI	225
Page		20a. Method of Disposition  1 Burial 2 Cremation 3   4 Donation 5 Other Specify:		Place of Disposition (No crematory or other place of Disposition (No crematory or other place)		-4-11	20c. Location - City or	
Baltime permit. Pag Department Important: injury or of	,	21. Signature of Funeral Service Licenses	S-M00947	2 26011	Address of Facility  ADDUTAIN AS	. TASAD		21122
Physician /Medical Examiner			line. sphyxia		e of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
		Sequentially list conditions, b. H	ie to (or as a consequence o anging ie to (or as a consequence o					
it ii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c	e to (or as a consequence o					
760, icate be executed physician and the burial - transit	edical E	d. UNPENDED	AMENDED					
Box 68760, edeath certificate be the attending physicidifor the attending physicidifor the buring for use as the buring the buring the puring t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg  1 Live birth  4 Pregnant at time of de	2 Fetal dea		nancy	23d. Date of delivery Month	Oay Year
P.O. Be that the de med by the	by Phy	Part II. Other significant conditions	9 Unknown ontributing to death but not r	esulting in the underly	ng cause given in Part I.		acco use contribute to	_
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was an autopsy perform	prior to one death?	topsy findings available completion of cause of
Vital Rec ysician: The his certificate	B	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death (Check		esidence 6 Other	
ion of V tending Phy eath oe: After th the funeral d	ation: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury FOUND: Day, Year)	28b. Time of Injury FOUND: 1737 hrs	28c. Injury at Work?  1 Yes 2 No		w injury occurred ed self	
Division  To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certification:	3 V Suicide 6 Could not be determined	28e Place of Injury - At h	ome, farm, street, facto	ory, office building, etc.	or Town, Sta		ral Route Number, City ark, MD
o the Hos ithin 24 ho o the Fun	edical (	one) 2 Medical Examiner: 0	: To the best of my knowled in the basis of examination a nd manner stated.	lge, death occurred at and/or investigation, in	the time, date and place, an my opinion, death occurred	d due to the cause( at the time, date ar	s) and manner as stated ad place, and due to the	ed. e cause(s)
F » F 8	Me	29b. Signature and title of certifier	~		O.C.M.E.		29d. Date signed (Mo. June 1, 2011	nth, Day, Year)
		30. Name and address of person who could Ling Li, MD Assistant Med	npleted cause of death (Item dical Examiner 900		eet, Baltimore, MD 2	1223		
S: Regis		31. Date filed (Manth, Day, Year)	32. Registrar's Signaft	ure hered		-		

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month May  $20^{
m Year}_{11}$ 1751 P<sup>M</sup> David Lloyd Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death E1kton Ceci1 100 Coventry Court Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 23, Year 943 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Hours Yrs Pennsylvania Director 218-40-7830 68 Usual Residence of Deceden "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 Hermitage Drive 21921 United States 12. Was Decedent Ever in U.S Armed Forces? 196 1 X Yes 2 No If Yes, Give 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 70es? 2 □ No 1961-'e 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1963 1 ☐ Yes 2 X No Specify: 3 🗆 Widowed 4 💢 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouseman Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Franklin Brown Lucy Reedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Hutton/Companion 312 Hermitage Drive, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State cemetery, crematory or other place) May ' R. A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) West Chester, PA 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician TE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be execu 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death page 2 should be detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Day Year Pregnant at time of death 2 No a Unknown 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PRITENSIJA 1 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No Yes 2 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 6 X 100 Coventry Court Companion's Mother house 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurren Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: Natural Accident injury 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title 133510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLIES Newak DA 19702 0 Yearl 32. Registrar's Signature State 8 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ma<sup>₩onth</sup> 20ay 20 TE 1:50 A M Physician/ John J. Broda Medical 4c. County of Death Montgomery City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours April Day, Yea <sup>ear)</sup> 1929 1 🕱 M 2 🗆 F 82 PA 200-22-9289 Director Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State the Maryland Director Maryland Prince George's Silver Spring 1 Yes 2 No 10g. Citizen of What Country? Zip Code 10e. Street and Number 20904 3154 Gracefield Road Apt. 412 Funeral filed within 72 hours after death with Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Deceuded Armed Forces?

1 ☑ Yes 2 ☐ No 1950— Black, White, etc 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) County Government the County Land Planner other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental IImportant: If item 27 is marked of
any injury or other traumatic ever Sarah Madera Joseph Broda l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Serpentine Terrace, Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) Ellen Carroll / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 23, Gate of Heaven Cemetery May 1 1<sup>™</sup> Burial 2 □ Cremation 3 □ Removal from State Silver Spring, MD 4 Donation 5 Other (Specify) Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 of Funeral Service Signa re 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Mycocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Bilateral Parietal CVA Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Pneumonia as the burial-transit Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Metastatic Disease from Unknown Primary to Liver, Lung, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Adrenals and Peritoneum, Coronary Artery Disease, autopsy After this certificate has perform page Yes 2 N 1 Yes 2 No Parkinson's 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Yes ᅆ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: injury Hospital or Attending 24 hours after death. 1 Natural Accident 5 Pending vithin 24 hours after death.

4 the Funeral Director: A sompleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Burbara

31. Date filed (Month, Day, Year,

D 0065485

1500 Forest Glen Road, Silver Spring, MD 20910

Suparuch RSM MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barbara Supanich, MD

MAY 23 2011

05/20/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- State of Maryland / Department of He Registrar Certificate of D		tal Hygier	CUIL	18204			
Physici /Medic		1. Decedent's Name (First, Middle, Last)  Gabina Bonilla			Day Year	3. Time of Death 7:30 a M			
Examin Funeral Director	er	578-74-2731 1 M 2 X F 90 Yrs. Months Days	Spring If Under 24 Hrs. 8. [	Date of Birth	Montgomer  9. Birth	y place (State or Foreign ntry) Salvador			
Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 X Yes 2 ☐ No			
th with the 23e or 28	Funeral Director	10e. Street and Number 10f. Zip Code 2700 Barker Street 20910	)		Citizen of What Cou $\mathrm{U}_{ullet}$ $\mathrm{S}_{ullet}$ $\mathrm{A}_{ullet}$	ntry?			
.0036 hours after death with the Maryland turel; or Itams 23e or 28a-1 show all Examinat must be notified at	by	1 Never Married 2 Married 1 Ves 2 No	panic Origin? (Specify, Mexican, Puerto Rica	an, etc.)	14. Race - Ameri Black, White Specify: Whi	etc.			
C 2 2 3	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 st  16a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)  Cook		16b	Kind of Business/Ir	•			
and 2121 d be filed within sntal Hygiene. ted other than "c event, the Me	Be		18. Mother's Name (Fi		36	imame)			
re, Maryland s 1 and 2 should be 1 f Health and Mental I item 27 is marked o other traumetic eve	5	19a. Informant's Name/Relationship (Type, Print)  Marlene Fuentes (Granddaughter)  5714 Foot	O 1		ty or Town, State, Zi				
iges 1 and to f Heal		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Oponation 5  Other (Specify)	Date )	20c	Location - City or T	own, State			
Balting permit. Pa Departmen Importent any injury		21. Signature of Funeral Service Licensee W. H. Baco 3447 14th	of Facility on Funeral Street.N.W	Home, I	nc. ington, D	.C. 20010			
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	, such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death			
fare be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):							
.O. Box ( the death certil y the attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 □ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐			23d. Date of deli	very Day Year			
ds, P.	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I.	23e. Did tobac	co use contribute to				
	Completed	Pour intake Adult failure to thrive.	Pour intake 20 Adult failure to thrive.						
ion of anding Physiath. or: After this ne funeral di	Certification: To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA  27. Manner of Death  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?	at 28d.	5 🗌 Residence	njury occurred t and Number or Ru				
Divis To the Hospital or Atterwithin 24 hours after de To the Funeral Difecto	edical Cer	29a. Certiflier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opi and manner stated.							
To the within 2 To the complex	Med		number 43121	29d.	Date signed (Month	n, Day, Year)			
		30. Name and address of person who completed and of death (Item 3a) (Type, Print)  NURUL CHOWDIMURY, MD; 15716 D; no D;	rin, Bu	rtonsv	ille, my	20866			
Sta Regist		29c. License 20c.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of D Time of Death Physician/ Month GOA M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Arunde1 Anne 8. Date of Birth (Month, Day, Feb 7 Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Hours 1 M 2 M Months Director 213-22-1576 1929 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 🗆 Yes 2 🏋 No Annapolis 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 940 Bay Forest Apt 206 21403 USA "natural", or items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Black of Health and Mental Hygiene.

of Health and Mental Hygiene.

If item 27 is marked other than "natural if item 27. Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States College (1-4 or 5+) Elementary/Seconday (0-12) 12th Laundry Department Naval Academy Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Carter Etheldia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Wigeon Way Unit 207 Gambrills, Md.21054 Joy Walker(Daughter) 20a. Method of Disposition 20b. PIPC 205 Disposition (Mame of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 5-20-11 Annapolis, Md. Winname Resease of Becility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Lavry 821 West St. Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 - Fetal death in the past 12 mont Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to death? autopsy performed 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\begin{array}{c} \begin{array}{c} \text{Nursing Home} \\ 2 1110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of OSPICE Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending HOUSE 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier a completed cause of death (Item 23a) (Type, Print) 'M Name and address of person w TAYLOR LUT DEFENSE HWY A VE IGHH tooI

State Registrar 31. Date filed (Month, Day, Year) **MAY 182011** 

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 18206 Michael John Birchfield State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Da May 21, 2011 1515 hrs Birchfield Medical Examiner Michael John c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Queen Anne's Stevensville 356 Wicomico Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** oreign Maryland Country) Months Days Hours Director 215-64-3923 55 08/26/1955 1 X M 2 F Yrs Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location 10b. Count Stevensville 1 Yes 2 X No Oueen Anne's MD or 28a-f show hours after death with the Maryland rector 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21666 356 Wicomico Road or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 2 X No Yes White 1 Yes 2 X No specify: Specify: 4 Divorced If Yes, Give Year 3 Widowed event, the Medical Examiner ፩ 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 b Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r injury or other traumatic event, the Medical E Construction Construction Worker Baltimore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche E. Couch John H. Birchfield Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 356 Wicomico Road Stevensville, MD 21666 Judy Birchfield / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date June 08, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State Lester, WV Birchfield Cemetery 2011 4 Donation 5 Other Specify:
21. Signature of Eureral Service Licensee Severna Park Funeral Home Severna Park, MD 21146 Barrand Address of Soris, P.A. 495 Ritchie Hwy, 23a. P. d. I. Endy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Alcohol and Alprazolam Intoxication Immediate Cause (Final disease Èxaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and -Physician/Medical AMENDED 23a, 27, 28a-f, per me, g9166-17-11 sm₩ UNPENDED attending physician or use as the burial of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 1 Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 歹 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an certificate has been prior to completion of cause of autopsy death? 2 🔲 No page ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical director, examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c Injury at Work? 27. Manner of Death Subject intentionally ingested prescribed medication with 1 Natural 1 Yes 2 X No Division 5 Pending Director: fd 5-21-11 fd 2:58 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 356 Wicomico Rd. Stevensville, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide 6 Could not be Residence determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. May 22, 2011 Brasself, 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD

State Registra

31. Date filed (Month Day Your) 2 2011

OCME

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #23ab per phy 5/19/2011 State of Maryland / Department of Health and Mental Hygiene A CO. Health Dept For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day /3 Betty Bonkowski 9:40 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Hospital Prince beone's center MD chevery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔼 F Months Hours Min 60 Washington, DC Yrs Director 220-56-7230 22/1951 Usual Residence of Deceder "natural", or items 23a or 28a-f shove a real Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland | Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10108 Marguerita Avenue 20769 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Completed 3 🗌 Widowed 4 🗌 Divorced White Year or Dates Me fical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 9 House Cleaning Self\_Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Geraldine Evelyn Frazee Ernest Frederick Shirley and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trat once. 10108 Marguerita Avenue Glenn Dale, MD 20769 Matthew L. Bonkowski/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/20/2011 l Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Hepatic <sup>p</sup>hysician/ disease or condition resulting in death) Encephalopathy Medical Due to (or as a consumence of) 20 monic Alcohol Abusa **Examiner** Failure Heoatic Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Alcoholic attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Elevated INR Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown signed by t d be detach Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated to page 2 should to 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No **Director:** After this certificate I in by the funeral director, pag 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Direction of filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive Cheverly, MD 20785 Tsion Berhane, MD 31. Date filed (Month, Da Registrar's Sigi State 192011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Iva Catherine Benner May 27 2011 6:40 P.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Mennonite Home Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 👿 F 87 Aug. 12, 1923 MaryTand Director 220-34-0978 or 28a-f show nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland satment of Health and Mental Hygiene. or orders it item 27 is marked other than "natural", or items 23a or 28a-f sho orders; if item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Md. Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21740 13436 Maugansville Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, 1 X Never Married 2 Married 1 Yes 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify. White 3 - Widowed 4 - Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic House Cleaner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Elizabeth Eshleman Penrose Benner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John V. Rudolph Sr. P/R 21835 Old Forge Rd. Smithsburg, Md. 21783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot once, May 31, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stouffers-Pondsville Smithsburg, Md. 2011 Ceme tery 22. Name and Address of Facility 21. Signature of Funeral Service Liger 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 Smithsburg.Md. Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ DA9231.VR disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 🔀 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No injury 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Blut Son

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<sup>Day</sup> Physician/ JUNE HARRY LEONARD BROOMALL 2011 12:15pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kent 14110 East Beechwood Rd. Galena Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Jan 19 211-28-0053 75 <sup>Y</sup>936 Pennsylvania Director Yrs Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.

Rant: If ifew 27 is marked other than "natural", or items 23a or 28a-f sho iruy or other traumatic event, the Medical Examiner must be notified at, pury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Galena 1 Yes 2 XNo Kent 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14110 East Beechwood Rd. 21635 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Plastic Elementary/Seconday (0-12) College (1-4 or 5+) Plastics Manufacturing Exec. Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Samuel Nicholas Broomall Helen Grace Peet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14110 East Beechwood Rd. Galena, MD. Patricia Broomall (wife) 21635 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kent Cremation 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/6/11 Smyrna, DE. 4 Donation 5 Other (Specific Galena Funeral Home of Stephen L Schaech 118 West St. Galena, M00510 Cross MD. nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause or each line. Immediate Cause (Final Onset and Death Physician disease or condition 0 Medical resulting in dead Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Cirector After this certificate has been signed by the attending physician and tran Due to (or as a consequence of). resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Day Pregnant at time of death 2 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tor After this certificate has the funeral director, page 2 t perform 2 No Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05/20/2011 10:05am Cox Mary Regina Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 14904 Lear Lane Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F 209-20-4040 May 05, 1927 Pennsylvania **Director** 84 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maruland Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 14904 Lear Lane 20905 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗓 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 X Widowed 4 Divorced White. Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ MGA Magazine Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Koeck Regina Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Cox - Son 9512 Greenel Road, Damascus. Maruland 20872 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 05/24/2011 | Silver Spring, MD . Signature of Funeral Service Links ee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Neva M. 11800 New Hampshire Ave., Silver Spring. W01691 MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line terval Between MULTIFORME Immediate Cause (Final 3 nset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate Examine if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Ciui tu (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate he funeral director, page 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MOCRNY 30. Name and address of tenson who completed cause of death (Item 23a) (Type, Print) , CRBII, IM-16, BALTO ORLEANS ST TIGNO State 23 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	e Type or Pri					-		Legible.			
	•	For State Registrar		aryıarı ———		oartment of F ertificate of L		, ,	Reg. No.	2011	18211		
Physician Medic		1. Decedent's Name (First, Middle, L Dorothy Elizabe						2. Date of Dear Month May 1		201 I Year	3. Time of Death 11:30 A M		
Examine	er	4a. Facility Name (if not institution, gi Kline Hospice Ho					Location of Death	,					
Funeral Director		5. Social Security Number 6. 130–14–7708	Sex 1 □ M 2 👺 F		ast birthday, 5 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 3	Year) 19	9. Bir Co New	thplace (State or Foreign untry) York		
fand show dat	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or L						10d. Inside City Limits		
the Mary or 28a-f notifie	Funeral Director	Maryland Fre  10e. Street and Number	derick		Wo	odsboro			10a. Citiz	en of What Co	1 ☑ Yes 2 ☐ No		
s 23a bust bu	eral	203 North 2nd St	reet			21798	8		_	ted Sta			
fter or amin	ρ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 👿 Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates.	. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🄀 No	n, Mexican, Puerto I	4. Race - American Indian, Black, White, etc. Specify: White							
n 72 hou e. an "natu Medical	Completed	15. Decedent's (Specify only highest to Elementary/Seconday (0-12)	Education grade completed) College (1-4 or 5	edent's Usual Occup e kind of work done o DO NOT use retired)		ng	16b. Kin	b. Kind of Business Industry					
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Ild be filed Mental H rarked ot atic ever	To B										ink)		
nd 2 shou salth and n 27 is m er traum		19a. Informant's Name/Relationship Elizabeth Murphy		c	1	North 2nd			-		o Code)		
Page 1 ar nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		C	emetery, ch	position (Name of ematory or other place on Cremato	<sup>е)</sup> Мау 14	Date 2011		erick,	Town, State Maryland		
permit. Departr Imports any inji		21. Signature of Funeral Service Lice	nsea	'	i	22. Name and Addres Resthaven 9501 Catoo	Funeral S	ervices ain Hwy	, Sk Fr	kot Co	dy P.A. k, MD 21701		
Dhaniston		23a. Part 1. Ther the 15g se, or co shock or heart f. Urre. List only Immediate Cause (Thal	one cause on each line	э.	n. Do not er	nter the mode of dying					Approximate Interval Between Onset and Death		
Physician/ Medical Examiner		disease or condition resulting in death)  a. Cancer of the Vulva  Due to (or as a consequence of):											
p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
be executed sician and burial-transit	I Exar	that initiated events resulting in death) Last  Due to (or as a consequence of):											
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To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medi	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live Birth 2   Fetal death 3   Ectopic pregnancy 1   Wonder State S								3d. Date of de Month	ivery Day Year		
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nysicia iis cert direct		examiner? 1 ☐ Yes 2 🏋 No	Hospital:	ent 2 🗆	ER/Outpati	ent 3 DOA Othe			ence 6 D	☑ Other (Spec	Hospice ify) House		
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he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 Medical Example)	nysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or inve	estigation, in my opinic	in death occurred at	the time date an	d place a	and due to the	cause(s) and manner stated		
Vith Voit Com.		29b. Signature and title of certifier	uckert	- C	RIP	29c. License				signed (Month			
5'		30. Name and address of person who Diane Ruckert, C	completed cause of d	eath (Item	23a) (Type, Ave.,	Print) Frederic	k, MD 217	01		, ,			
State		31. Date filed (Month, Day, Year)	2011 32. Registra	ar's Signat	ure /	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr., g916,06/17/2011dhb Certificate of Death 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month idney J. Cohen Medical 4a. Facility Name ( not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Re Montgomery . Birthplace State or Foreign If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 215-40-3191 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 79 Months Hours Min Oct 10 4 1931 Massachusetts Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Montgomery Potomac 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 20854 11201 Gainsborough Road United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ō 2 Baltimore, Maryland 21215-0036 If Yes, Give 1960-1964 Year or Dates. 1 Yes 2 No Specify. 'natural", Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important; If item 27 is marked other than any injury or other trainmetic. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Be 18. Mother's Name (First, Middle, Maiden Surname) Jennie Goldenberg 17. Father's Name (First, Middle, Last) မ Jacob Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11201 Gainsborough Road Potomac, Maryland 20854 Geoffrey Cohen -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gdns. 5/20/2011 Falls Church, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Bonald W. Bofgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Onset and Death Prysician/ in tection Medical resulting in death) Due to (or as a Examiner Sequentially list conditions. rany, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-tracuit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached if 9 Unknown Division of Vital Redords, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure, Diabetes 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to modical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural Accident 5 Pending 2 🔲 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Fractioner: To the cost of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29c. License number 29d. Date signed (Month, Day, Year) 10+1 O30. Name and address of person who completed caus of death (Item 23a) (Type, Print) hett

State Registrar Date filed (Month, Day, Year) MAY 23

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32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 5/15/2011 1035 Physician/ David Lloyd Deal Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Odenton 519 King Malcolm Ave. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 🖾 🎢 2 🗆 F 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. MO7.84.1941 Country) MD 69 215-40-7734 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director 1 Yes 2 No MD Anne Arundel 0denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 519 King Malcolm Ave. 21113 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 No 1959—

If Yes, Give 1082 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by White Maryland 21215-0036 Yes XX No Specify: ¾X Widowed 4 ☐ Divorced 1982 Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Space Flight Industry Manger Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Ruth Shaggue Madison Lloyd Deal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5656 Mills Field Lane Port Republic, MD 20676 Brenda Ortiz Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place cemetery. 5/20/2011 |Marriottsville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cancel Physician 10+cste1 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 4 Pregnant 9 Unknown Pregnant at time of death , the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s 2 No within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 2 No 1 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ဂ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my, owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinat and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 <u>|</u>3 <u>|</u> (Check Certifying Nurse Practioner: To the best of m, nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 PUTSR Z & 11 ED 11: 30. Name and address of person who completed cause of death (Firm 23a) (Type, Print) Wedentun

Registrar DHMH 17 Rev 7/2009

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gistrar's Signature

Mark

1172 Annepolis

Amend #29d per Phy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5/19/2011 AA Co. Health State of Maryland / Department of Health and Mental Hygiene																
Dept lo	1 - State Registrar Certificate of Death Reg. No. 2011											18214				
		1. Decedent's Name		2. Date of D						Death 3. Time of Death						
Physician Medica	al .	Albert B. Doyon										Month 5	_		Year	0200 м
Examine	r	4a. Facility Name (if							Location		4c. County of Death					
Funeral		Anne Aru  5. Social Security Nu		1edical 6. Sex			ast birthday)	If Unde	r 1 Year	polis If Under	24 Hrs.	8. Date of Bir	rth	Anne Arunde1  9. Birthplace (State or Foreign		
Director		212-42-2214  Usual Residence of Decedent			F	67	Yrs.	Months	Days	Hours	Min.	(Month, Day, Year) 10/22/1943			Cour	NH NH
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ē	10a. State	10b. County			10c. City	y, Town or Lo	cation								10d. Inside City Limits
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6 ter de mine	by F	1 Never Marri	ed 2 <b>XX</b> Mar	ried 1 🔀 Y	Forces?	1.0	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							Black	Black, White, etc.	
003 urs aff urral",	ed ed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.					969						Specify: White			
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Ylaı Ild be Ment narke	우	Albert B										Camer	_			
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and 2 Healt tem 2	-	Marie E.  20a. Method of Disp			W	20b. F	Place of Disp	osition (Na	me of	- :		late		Location -		
mol		1 ☐ Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal fi	rom State		emetery, cre Lantic				5/12	/2011	G1	.en Bı	rni	e, MD
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important, if item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examone.	1	21. Signature of Fur								-		desty	Fune	ral H	lome	, P.A.
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		·	t failure. List o	complications the only one cause or	nat cause n each lin	d the deat e.	h. Do not en	er the mod	de of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between Onset and Death
→ Physician/ Medical		Immediate Cause (I disease or condition resulting in death)		a	to (or oo	a censequ	29 col	ltou	y	16	ecu	ie .				Onder and Death
Examiner		22 22222		Due	(U) (U) as	Rei	we	N	eud	713	ing	Par	ico	atet	is	
	ner	Gequentially list con if any, leading to im- cause. Enter Under	mediate	Due	to (or as	a consequ	uence of):			0	1					
executed an and rial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) I	iinjury S	c. —	to (or as	a consequ	ience off.									
- <u> </u>	_ 1	resulting in death) t	_d51		10 (01 43	a consequ	201100 01).									
Division of Vital Records, P.O. Box 68760 ral or Attending Physician: The law requires that the death certificate be. rs after death.  In Director: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bur	Physician/Medica			a										0		
x 68 n certif	<u></u>	IF FEMALE: 23b. Was decedent		23c. If yes,	outcome ive Birth	of pregna	ncy al death 3	☐ Ectopic	pregnanc	v				23d. Date		
Boy death he att led for	SICE	in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 🗆 F		at time of o		Other (s		,				Mor	ith	Day Year
at the detach	[ ]	Part II. Other signifi	icant condition	ons contributing	to death I	but not res	ulting in the	underlying	cause giv	en in Part	il.	23e. Did	tobacco	use contri	bute to t	he cause of death?
S, P	g Q											1 🗆	Yes 2	2 🗌 No	3 🗆 Pro	bably 4 Unknown
ord v requisibeen shoul	Completed											24a. Was				psy findings available
<b>3eC</b> he law te has age 2	Ĕ											auto perf 1  Yes	opsy formed?	d	eath?	empletion of cause of
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· Vit hysic his ce til direc	의	1 ☐ Yes 2 ☑	No	Hospital:			ER/Outpatie	. T		4 ∐ N		me 5 Res				y)
n of ding P n. After t funera	ate	27. Manner of Death Natural	5 Pendir	ng (A	ate of inju Nonth, Da		28b. Time o injury	M I	28c. Injury work' 1 □	≀at ? Yes 2.⊑		28d. Describe	how inju	ury occurre	d	
Siol Attendar r deat cctor: by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investi 6  Could determ	not be 28e. Pl	ace of Inj	ury - At ho	me, farm, st			103 2	_				r or Rura	I Route Number,
Divi		4 🖂 Homicide	detern	bi	uilding, et	c. (Specify	1)					City or To	wn, Stat	re)		
Hospit Hour Hour Hour Hour Hour Hour Hour Hour	Medical	(Check 2	Medical I	Physician: To the	basis of e	examination	n and/or inve	stigation, in	my opinio	n, death o	ccurred at	the time, date	and place	e, and due	to the ca	use(s) and manner stated.
Division of Vital Records, P.O. Box 68760  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		only one) 3	Certifying	Nurse Praction	er: To the	best of m	y knowledge,	death occu	urred at the	e time, dat	e and place	e, and due to t	he cause	e(s) and mar	nner as s	tated.
F 3 P 8			Joly	14	004	ago	eile	6	D	437	37/	/	_0d. D	3/11	#	5/10/2011
9-11		30. Name and addre	ess of person	who completed o	cause of d	death (Hen	23a) (Type,	Print)	A	AM	C 0	7-001	Me	20er	al	PRACY
		Judy He	bert,	MD	1		-	,	- 11	,,.,,		Acres	apo	Zis	M	D 21401
State Registra	) r	31. Date filed (Monti	AY 19	2011	Registr	ar's Signa	19. A	ave					,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 15 Physician/ AM 6:55 Robert W. Elgin Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours Min. Month, Day, Ye 1944 Washington. 1 **X** M 2 □ F Director 67 579-54-7545 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1X□ Yes 2 □ No Maryland Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20715 12437 Melling Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Prince George's County Elementary/Seconday (0-12) College (1-4 or 5+) |School Svstem Electronic Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mvrtle Jones Charles B. Elgin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12437 Melling Lane Bowie, MD 20715 Judith A. Elgin/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Baltimore Washington | 5/22/2011 Laurel, MD 22. Name an Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Tue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 unknown sate has been signed by the a page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes Certificate: To Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d, Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29b. Signature and ti e of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7iba Shirani M.D State 19 2011 Registrar

only one)

3001 Hospital Drive Cheverly MD 20785

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2011 Month **Physician** FRIEDMAN David Louis 22, 3:26 A. May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 702 Kersey Rd Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birth (On 16, 1915 PA. If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday, **Funeral** Days 200-01-7183 1 M 2 □ F 95 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

The filem 27 is marked other than "natural", or items 23a or 23a-f show ant. If item 27 is marked other than "natural", or items 12 to make the traumatic event, I'm Midded Exat. In a must be natified as any or other traumatic event, I'm Midded Exat. 10a. State MD 10c. City, Town or Location 10d. Inside City Limits Montgomery Silver Spring 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 20902 702 Kersey Rd. U.S.A. by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College\_(1-4or 5+) Manufacturing Research Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Landy Benjamin Friedman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 Kersey Road, Silver Spring, MD Sue White, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Park Cemetery 05/24/11 Warwick, R.I. 21. Signature of runeral Service Licensee 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Physician /Medical Due to (or es a consequence of): Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate ba executed burial tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the as attanding property for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signad by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 💢 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours after death.

To the Funeral Director: After this certific the ည

> State Registrar

29b. Signature and title of certifier

10810 Connecticut Avenue, Kensington, MD Jeffrey Drubis, M.D. 31. Date filed (Month, Day, Year) MAY 23 2011

30. Name and a dissi of terson wto completed cause of death (Item 23a) (Type, Print)

and manner stated.

NT

29c. License number

MD D18137

29d. Date signed (Month, Day, Year)

May 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Francis Xavier Faris  $P^{M}$ May 2011 2:40 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis . Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days 1 XM 2 - F Months Hours -1918 92 Pennsylvania 186-10-8335 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector Severna Park MD Anne Arundel 1 ☐ Yes 2 🕅 No ā 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ntal Hygiene. ed other than "natural", or items 23a or event, the Me ital Examiner must be i Funeral 4 Sunset Drive 21146 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, WW II Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White 3 Widowed 4 Divorced Korean Specify. Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Procurement Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Adelaide Haines Walter Aloysius Faris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Faris / Daughter 4 Sunset Drive Severna Park, MD 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2  $\square$  Cremation 3 X Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) cemetery, crematory or other place) May 21 2011 Resurrection Cemetery Bensalem, PA 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service 495 Ritchie Hwy. Severna 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ myo cardia Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examir and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burialphysician a Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death the hed 9 Unknown 9 Unknown is been signed by the should be detached Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s perform certificate 1 Yes 21 No Yes 2 No Division of Vital Be 25. Was case referred to medical director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No Hospital: ᅆ 1 【Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After K Natural injury 5 Pending s after death.

I Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af To the Funeral Di сотрleted filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 69566

State Registrar 2001 Medical

31. Date filed (Month, Day, Year)

Ivelisse

Pulia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkway

MAY 18201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Patricia 2011 Mav Ann Fisher 11:23 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Clinton Southern Maryland Hospital Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 1 🗆 M 2 🔀 F Days Hours 53 0871971957 Director Washington, DC 579-62-8661 Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director be notified 1 Yes 2 X No Prince George's Marvland Camp Springs Ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? **23a** 20746 USA 4703 Old Soper Road Unit # 449 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than " alth and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Alexander Elizabeth Α. Da1<sub>v</sub> Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 8507 Chase Glen Circle Fairfax Station, VA 22039 Susan K. Cooch / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 05/18/2011 Clinton, Maryland Resurrection Cem. George P. Kalas Funeral Home PA 21. Signatur AFuneral Service Licensee 22. Name and Address of Facility 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Par J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cau Interval Between Immediate Cause (Final Onset and Death Physician/ di sease disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death 3 Ectopic pregnancy for Day Month Year Pregnant at time of death 5 Other (specify) should be detached the ģ Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has all director, page 2 s autopsy performe 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 Other: 2 No 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death.
I Director: After the in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital o. within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert D0053219 son who completed cause of death (Item 23a) (Type, Office Road, Walder

DHMH 17 Rev 7/2009

State Registrar

20602

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Director 214-48-8339 1 M 2 K F 92 Yrs. Months Days Hours Min. Jan. 1919 Co	Inthplace (State or Foreign country) Italy  10d. Inside City Limits 1  Yes 2 No ountry?  Perican Indian, te, etc.  Industry  Industry
1. Decedent's Name (First, Middle, Last)  Nora Victoria Galli  Examiner  1. Decedent's Name (First, Middle, Last)  Nora Victoria Galli  4a. Facility Name (if not institution, give street and number)  3160 Gracefield Road, EV 2102  Funeral  Director  1. Decedent's Name (First, Middle, Last)  Month Victoria Galli  4b. City, Town, or Location of Death Silver Spring  4c. County of Death Silver Spring  7. Age (In yrs. last birthday)  1	th state of the s
4a. Facility Name (if not institution, give street and number) 3160 Gracefield Road, EV 2102  Funeral Director  Funeral Director  The street and number and street and number an	Inthplace (State or Foreign country) Italy  10d. Inside City Limits 1  Yes 2 No ountry?  Perican Indian, te, etc.  Industry  Industry
Director  214-48-8339  1 M 2 K F  92 Yrs. Months Days Hours Min. Jan. 1, 1919  Co	10d. Inside City Limits 1 □ Yes 2 ☑ No ountry?  erican Indian, te, etc. te
Usual Residence of Decedent    10a. State   10b. County   10c. City, Town or Location   Silver Spring	1 ☐ Yes 2 ☑ No ountry?  erican Indian, te, etc. te Industry
The street and Number and Status	erican Indian, te, etc. te Industry
11. Marital Status   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White Specify White Specify: White Specify only highest grade completed)   16b. Kind of Business   16c. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White Specify: White Spec	te, etc. te Industry
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	on
Elementary/Seconday (0-12) College (1-4 or 5+)  Teacher  Education	- Onda
To Be the transfer of the tran	- C- d-1
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig  F. John Galli/Son  3525 Raymoor Road, Kensington, MD 20895	p Coae)
20a. Method of Disposition  1 Date  20c. Location - City or cemetery, crematory or other place)  4 Donation 5 Other (Specify)  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cate of Heaven Cemetery  2011  Silver Spi	
21. Signatur & Funeral Service Licenses Cle Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring	g,MD 20901
23a. Part 1. Enter the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Conjective Heart Failure	Approximate Interval Between Onset and Death
Due to (or as a consequence of):  Arteriosclerotic Cardiovascular Disease	
If any, leading to immediate Due to (or as a consequence or).	
p p p p p p p p p p p p p p p p p p p	
Adabase. Cities and contributing to death) Last    FEMALE:   23b. Was decedent pregnant	olivery Day Year
The state of the s	
1  Yes 2 No 3 Properties and the properties of t	ntopsy findings available completion of cause of
Use 25. Was case referred to medical examiner?  Hospital:  Other:  Oth	
1   Yes 2   No   No   No   No   No   No   No	ify)
28a. Date of injury 28b. Time of injury 3 work?  28d. Describe how injury occurred work?	ral Route Number,
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  28. Date of injury  (Month, Day, Year)  28. Diagram  28. Di	cause(s) and manner stated
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month)  CRUP  P158/067  5/20/20	n, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Eileen Gemmell, CRNP 3160 Gracefield Road, Silver Spring, MD 20904	
State Registrar  31. Date filed (Month, Day, Year)  AX 2 3 2011  A 2. Registrar's Significant for the state of the state o	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2011 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elternhaus Assisted Living Dayton Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Dec. 11, 1915 **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Birthpia CA 1 M 2 XF Director 95 Yrs Dec. 545-20-2879 Usual Residence of Decedent show 2 should be filed within 72 hours after death with the Maryland thith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a fsho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🗌 Yes 2 🔀 No Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral 8014 Barron Street 20912 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give SpecifyWhite 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Elementary Teacher Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl Wilhelm Sullberg Alma Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elisabeth Ann Wear/Daughter 8014 Barron Street, Takoma Park, MD 20912 injury or other Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 2020 Alexandria, 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W, Silver 20901 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only or ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se \_\_\_\_\_ a.h line. Approximate Interval Between Immediate Cause (Final Onset and Death Y RIV Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months Year Month 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes Yes 25. Was case referred to medical Division of Vital Be director, 26. Place of Death (Check only one) Hospital 2 A No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number ed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

			e,fperFD Pleas t. 5924-11 KAH	e Type or Pri								1 5 6 6 1
		1	For State Registrar	State or ivia	aryianu		tificate of L	Health and N Death		erie201		18221
Physi	ician	1. Decedent's Name (First, Middle, Last)  Edmund P. Gilbert							Month			3. Time of Death
Me	edica mine	4	4a. Facility Name (if not institution, gi		4b. City, Town, or	r Location of Death	May	14, 201 4c. County of		1:42 A M		
LA	ıııııç	ı	Regency Park As:		Gambri			Anne Arundel				
Funer Direct	tor			Sex 7. Age 1 M 2 □ F	95 (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 11	Year) •1915	9. Birthpla Country New	ce (State or Foreign ) York
faryland 3a-f show tified at			10a. State FL 10b. County	Proward Arundel	10c. City, T	own or Loc	cation Pompa	no Beach			100	I. Inside City Limits 1 ☒ Yes 2 ☐ No
with the M s 23a or 28 ust be not	-	ruilerai Director	10e. Street and Number 2215 Ct 373 Westbury D	press Island i	Drive A	4pt.804	10f. Zip Code	33069 <del>10</del>	10	Og. Citizen of Wh	nat Country	ņ
Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hyglene. 'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	<u>.</u>	3	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates.			Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American , White, etc <b>Wh</b> :	
215-0 nin 72 hour ne. than "natu e Medical		Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12)	Education	11/1/11	(Give I life. D0	O NOT use retired)	during most of work	ing	16b. Kind of Bus		stry
and 21 be filed with ntal Hygier (ed other to sevent, the		ᅡ	17. Father's Name (First, Middle, Lasi Peter H. Gilbe:			Reg	gistered N	18. Mother's Nam	e (First, Middle, M H. Gokey	Hospit	_ <u>a</u>	
Baltimore, Maryland 21215-0036  bennit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam		H	19a. Informant's Name/Relationship  Gary Gilbert / 8	(Type, Print)				and Number or Rura  y Drive ]	al Route Number, (		ite, Zip Coo	de)
<b>Baltimore, Ma</b> permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau			20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		cem	etery, cren	sition (Name of natory or other place ematory,	<sup>(e)</sup> IMav	Date 2 17,	20c. Location - C	-	· ·
Balt permit. Departr Import	ouce.	1	21. Signature of Furieral Service Lice	nsee	•	ζŧ	EMATION 5 Ritchi			erna Pa	N	TD 21146
~ Physicia Medic	in/		23a. Part 1. Enter the dise se, or co shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	NG	Do not ente		g, such as cardiac o			A	pproximate nterval Between onset and Death
Examin	ner	5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a								
be executed sician and burial-transit		5 I	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a								
SOX <b>b8 / b0</b> leath certificate be attending physicial differ use as the burn	/M/ codi:		IF FEMALE:	d								
box 6  The death ce the attend	Division (Modic	i yalcıdı i	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 1 Pregnant at 9 Unknown	2 🗌 Fetal d	eath 3	Ectopic pregnand Other (specify)	<b>с</b> у		23d. Date Mont	of delivery h Da	ay Year
DIVISION Of VITAI RECORDS, P.O. Eq.  To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached.	0,4	2	Fait ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Parti.						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn			
Hecords, The law requires cate has been sig	o to to to	ombie							24a. Was an autopsy perform	, pri	ior to comp ath?	y findings available bletion of cause of
cian: Terrifica	3	3 2	25. Was case referred to medical examiner?	Hospital:				ace of Death (Check				Autol
OT VIII Physi r this o	F		1  Yes 2 No 27. Manner of Death	1 ☐ Inpatie	y 28	b. Time of	t 3 DOA Othe	4 ☐ Nursing Ho	ome 5 Resider 28d. Describe hov			HUING
On C ending sath. or: Afte he fune	100	200	1 Natural 5 Pending 2 Accident Investigati		Year)	injury	M 1 □	(? Yes 2 □ No		,		f
UIVISION OF VITAI ital or Attending Physician: urs after death. ral Director: After this certific led in by the funeral director,	100		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of Injurbuilding, etc.	(Specify)				28f. Location (Stre City or Town,	State)		oute Number,
the Hospi iin 24 hou the Funer	Modion		(Check 2 Medical Exa only one) 3 Certifying No	nysician: To the best of r miner: On the basis of ex urse Practioner: To the b	amination ar	nd/or invest	igation, in my opinio	on, death occurred at	t the time, date and	place, and due to	o the cause	
To t With To 1			29b. Signature and title of certifier	fly			29c. License	20094	29	OS 117	Month, Day	y, Year)
CAT			30. Name and address of person who	completed cause of de	eath (Item 23		rint)	fark 6	Prive (	flen 1	buche	P. 11/2,2106
S Regis	State		31. Date filed (Month Day Year)	011 32. Pegistra	r's Signature	4 1	0.41		,			, ,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 19, Month MAY 2011 7:10 AM GRACE HOWARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING Social Security Number 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funerai Days (Month, Day, Ye MARCH 26 Months Min 1 □ M 2 💢 F Director 90 TENNESSEE 491-18-8206 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No MD. MONTGOMERY SILVER SPRING 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2501 MUSGROVE RD. 20904 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify "natural", Completed Specify: 3 Widowed 4 X Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 NEVER WORKED NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ HOWARD DAISY MAE SCOTT CLARENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 PAMELA DENNISON/DAUGHTER 9039 SLIGO CREEK PARKWAY #1570, SILVER SPRING, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY MAY 21,2011 RIVERDALE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL
5801 CLEVELAND A Signature of Funeral Service Licenses L HOME & CREMATORIUM,P.A. AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) RESPIRATORY FAILURE Medical Due to (or as a consequence of) **Examiner** END STAGE LUNG DISEASE Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial The law requires that the death certificate be executed CHRONIC OBSTRUCTIVE PULMONARY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) Yes \_ Unknown be detached Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 

Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page 2 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 2 Accident
3 Suicide
4 Homicide 2 No Investigation completed filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

**TAYAG** 

31. Date filed (Month, Day, Year)

D63579

1500 FOREST GLEN RD., SILVER SPRING, MD.

MAY 20, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 May 12. 8:20 Рм Marie J. Hargett Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Crofton Care & Rehab Crofton 9. Birthplace (State or Foreign Country) **No. Carolin**a Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes June 15. 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕇 F Min. Days Hours 402-46-6060 85 Director Yrs 1925 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie Y Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2919 Tallow Lane 20715 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced "natural", SpecifyWhite Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 4 Collegiate Piano Teacher Music is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Phillip Johnson Marie Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis McNeill / Sister 2919 Tallow Lane, permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Metro Crematory 5/14/2011 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest parck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final Athenosclenotic Candiovascular Disease Physician/ disease or condition Medical resulting in death) Examiner andiovasarlas Distan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or as a consequence of Exami death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day signed by the a 1 Yes 2 No that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of this certificate has pade death? performe 1 Yes 2 No Yes 2 Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it Natural Accident 5 Pending work? 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Rakesh Arora,

MAY 182011

31. Date filed (Month, Day, Year)

Bowie,

MD

14300 Gallant Fox Lane

Amend #23ab & 24b per Phy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5/19/2011 AA Co. Health Dept State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $^{\text{Day}}_{14}$ Morris  $2^{-2}0^{7}11$ Lester Hennessey May 1700 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2528 Flowering Tree Lane Gambrills Anne Arundel 5. Social Security Number **Funeral** Sex 1₩M 2 □ F 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 MD Months Days Hours **Director** 220-36-4402 71 2972971340 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Gambrills 1 Yes X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2528 Flowering Tree Lane 21054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner 14. Race - American Indian, Armed Forces?

1XXyes 2 \sum\_{No} Vietnam

If Yes, Give Black, White, etc. ò þ 1 Never Married 2 Married 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Chief Sanitarian State of Maryland Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lester Hennessey permit. Page 1 and 2 should be Department of Health and Ment Important. If item 27 is marke any injury or other traumatic once. other traumatic Ruth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Lambeth Daughter 1405 Rolling Place Belair, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland Veterans 5/23/2011 Crownsville, MD 21. Signature of Funeral Sen to Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Frysician/ Onset and Death Kut coronary Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying o (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Mornd Due to (or as a consequence of): physician at the burial-t Physician/Medical Box 68760 attending physi IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 No WH 1 ☐ Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referre examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cther (Specify) မ 2° No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 4+1 cause of death (Item 23a) (Type, Print) crofton, mo 2111-State 32. MAY 192011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Wilson Hatch Month 2011 AΜ 6:00 May 18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Kris-Leigh Assisted Living Severna Park 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 26, 1928 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1**XX**M 2 □ F Months Hours 424-22-6425 82 Director Kentucky Aug. Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Maryland Anne Arundel 1 Yes 2XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2000 Elmwood Road 21409 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1☎Xves 2 □ No If Yes, Give Year or Dates. 1946–67 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2X Married Specify: White 1 Yes 2XXNo Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Major U.S. Marine Corps traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Daisy Elizabeth Wilson 0 Charles Kramer Hatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Shirley Hatch/wife 2000 Elmwood Road Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Baltimore Crematory : 5/20/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral 9 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Diverticular bleeding disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): nding physician use as the burial Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year Pregnant at time of death the ed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 Tes 2 X No 3 Probably 4 Unknown been si should I Completed COPD 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed' death? certificate 2 🗆 No Yes 2XXN 25. Was case referred to medical Hospital or Attending Physician: director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2XX No Other: ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4XXNursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 X Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature ap 29d. Date signed (Month, Day, Year) May 18, 2011 D0054903 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3×. Frederick Karkowski, MD 139 Old Solomons Island Road Annapolis, MD 21401

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) **MAY 19** 2011

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

**Division of Vital** 

parke

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 31,2011 Physician/ PEARL JEWEL HALL 6:20A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16606 BEALLE HILL ROAD WALDORF PRINCE GEORGES Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex Funeral Age (In yrs. last birthday) Month, Pay, Year) 23 VA. Months Min. 1 □ M 2 🏋 F 408-56-0612 88 Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified and once. PRINCE GEORGES WALDORF 1 Tes 2 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16606 BEALLE HILL ROAD 20601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LEE DESKINS SARAH HALL 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16606 BEALLE HILL RD. WALDORF, MD. 20601 NORMAN HALL-SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State INITY MEM GARDENS 6-7-11 WALDORF, MD. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee M00479 e and Address of Facility MOND FUNERAL SI PLATA, MARYLAND 23a, Part 1, Film the disease, or complications that c ... d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of ch line Immediate Cause (Final disease or condition ULMONARY Physician/ FIBROSIC Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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resulting in death)	Due to (or as a consequence of):										
Sequentially liet conditions,	HYPOXIA										
if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a consequence of):										
resulting in death) Last	Due to (or as a consequence of):  d	Due to (or as a consequence of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year								
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?  2 \( \backsquare \) No 3 \( \backsquare \) Probably 4 \( \backsquare \) Nhown								
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 ■ No								
25. Was case referred to medical examiner?	26. Place of Death (Check	only one)									
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 Residence	6 ☐ Other (Specify)								
27. Manner Death  1 V atural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	(Month, Day, Year) injury work?  M 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred								
4 Homicide determined			f. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exam	vsician: To the best of my knowledge, death occured at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred at rse Practioner: To the best of my knowledge, death occurred at the time, date and place	the time, date and pla	ce, and due to the cause(s) and manner stated								
29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)								
1 SWAN	C PHYSICIAN DS3787	2	MAY 312 2011								

LIVINGSTON ROAD, SUITE \$ 101, FT. WASH

State Registrar

**ORIGINAL** 

11701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMBRICK Month 10:27 RM 5.0 0.5 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MARYS NURSING CENTER EON ARD TOWN MARYS Security Number . Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Min 1 M 2 K WEST VA **Director** show or 28a-f show 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ST. MARY'S LEONARDTOWN MD 1 X Yes 2 No 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21585 PEABODY STREET 20650 U. S. A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural". Completed 3XXWidowed 4 ☐ Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) ift. Page 1 and 2 should be new arment of Health and Mental Hygiene arment of Health and Mental Hygiene. HOUSEWIFE AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည WILLIAM WHITE MYRTLE (UNAVAILABLE) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY C. HAMBRICK/SON 27010 BUDDS CREEK RD. CHAPTICO, MD 20621 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place METRO • CREMATORY Important: If any injury or JUNE 1,2011 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA Signature of Funeral Service Licens 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ -AILURE 10 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AMPUTATIONS Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last PERIPHERAL Votscuur Due to (or as a consequence of) Physician/Medical PERTENSIO To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death
Unknown the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MULTIPLE SCIENOSIS; DEMENTIN; 1 Yes 2 No 3 Probably 4 Unknown GASTROESONAS GER REFLUX OLSENSE Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? STATUS-POST GARER GI BLEEDING; GASTAGES; ANE certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 201 24635 Registrar

**ORIGINAL** 

↓ DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 15 2011 1910 May Estella Pye Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bowie Health Center Prince Georges Bowie If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral 1 □ M 2 😾 F Florida 10/15/1930 Director 265-38-3312 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience is ust be notified at Yes 2 No Directo Bowie Prince Georges MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 Peartree Drive 15102 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces2 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates: Black þ 3 ☐ Widowed Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DQNOT use retired)
Association of Retarded
Citizens Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Montgomery County 12th 18. Mother's Name (First, Middle, Maiden Surname) unknown 17. Father's Name (First, Middle, Last) Be Lillie Bell White ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daughter Elizabeth D. Rhodes Elizabeth D. +5102 Peartree Dr. Bowie,MD 20721 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Brentwood, MD 5/20/11 Ft. Lincoln 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licens 3831 Georgia Ave. NW Washington, DC 20011 cc0278 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Diabetes Mellitus disease or condition resulting in death) Hospital or Attending Physician: The law requires that the death certificate be executed ate of delivery Year

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

attending physician and I for use as the burial **regis**i certificate has been signed by the rector, page 2 should be detached funeral director, within 24 hours after death.

To the Funeral Director: Aft pompletely filled in by the fun

Division of Vital Records, P.O. Box 68760,

		Due to (or as a consequence of):							
1) (E	O	b. Hypertension	_						
	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):							
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	Cerebrovascular Disease							
X	resulting in death) Last	Due to (or as a consequence of):							
cal		d							
ysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2♣ No 9 □Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	elivery Day Year						
d by Pn		contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?  Probably 4  Unknown					
Completed			autopsy prior to	utopsy findings available completion of cause of s 2 \( \sumbol{N}\)o					
Re C	25. Was case referred to medical	25. Was case referred to medical 26. Place of Death (Che							
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hom	Home St☐ Residence 6 ☐ Other (Specify)						
ition: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 \( \text{Yes} \) 2 \( \text{No} \)	8d. Describe how injury occurred						
Certification:	4 L Homicide	determined building, etc. (Specify)  City or Town, State)							
=	29a. Certifier 1 Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause(s) and manner	as stated.					

29d. Date signed (Month, Day, Year)

20708

May 18, 2011

Laurel, MD

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Pritam Saini, MD

MAY 23 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28998

Suite 211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MA Physician/ 20/ SUSAN JOHNSONI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MEDICAL ANNAPOLIS ANNE ARUNDEL PRUNDE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days 033-07-665 Hours 1073171918 Massachusetts Director Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file and 23a or 28a-f sho and the file 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bowie 1 X Yes 2 No Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12303 Skylark Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Completed 3 X Widowed 4 ☐ Divorced White Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Massachusetts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Puniskis Veronica Mensevaciuta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth S. Shea/ Daughter 12303 Skylark Lane, Bowie, MD 20715 Department of Health Important: If item 23 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mooreland Cemetery 05/21/2011 Paxton, Massachusetts 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fineral Service Licensee 6512 NW Crain Hwy., Bowie, MD 20715 Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ MYOCARDIAL INFARCTION ACUTE disease or condition **Medical** resulting in death) Examiner SPIRATION Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine EM BOLISM and the burial-tran Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the buria e Hospital or Attending Physician: The law requires that the death certificate be to a Nours after death.

12 Hours after death.

Funeral Director: After this certificate has been signed by the attending physicia er Loneral Director: After this certificate has been signed by the attending physicia set after During lighted filled in by the funeral director, page 2 should be detached for use as the burnilled the director page 2 should be detached for use as the burnilled the director and the property of the Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၣ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 □

State

Registrar

VILLANHEVA 31. Date filed (Mont 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

- Anne Arundal Med Center, 200; Medical Pking

29c, License number

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** MAY Delores M. Johnson 7 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Arno1d Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. Nov 4 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔽 F 219-30-1381 Mărÿ1and Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r items 23a or 28a-f shor 1 ☐ Yes 2 ₩ No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1354 Shirleyville Rd. 21012 USA Funeral death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 ŏ of Health and Mental Hygiene. Item 27 is marked other than "natural", or other traumatic event, the Medical Expt. 1 ☐Yes 2X No 5 Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th 0 Caregiver Private Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Horace Maynard Rachel Woods 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy E. Johnson (Daughter) 1354 Shirleyville Rd. Arnold, Md. 21012 Department of Heal important: if Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 5-23-11 | Crownsvil Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Physician ANCREATIC resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Yes 2 | ₩0 Other: 4 2 Nursing Home 5 Residence 6 Other (Specify) this Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident filled in by the 6 Could not be 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1-03988 Iwood Johnson		Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental I			1 1000				
		1- For State Certificate of Death	R	20 I eg. No.					
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last)  Elwood James Johnson, III	2. Date of Dea Month May 28, 2	Day Year	3. Time of Death 1039 hrs				
		4a. Facility Name (if not institution, give street and number) 467 Sulmar Road 4b. City, Town, or Location of Dea	ath	4c. County of E					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 15. Social Security Number 219-42-9527 1 M 2 F 66 Yrs.  16. Sex 7. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Days Hours Min. 10/19/1944  10/19/1944							
with the Maryland ns 23a or 28a-f show any be notified at once.	Director	10a. State 10b. County 10c. City, Town or Location  Maryland Cecil Rising Sun  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	10d. Inside City Limits 1 Yes 2 X No Country?				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fah injury or other traumatit event, the Medical Examiner must be notified at once	Funeral	467 Sy1mar Road  11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 2 Yes 2 No 2 Yes 2 No specify:		United  14. Race - A White, e	merican Indian, Black, tc.				
11215-0036 Id be filed within 72 hours af fental Hygiene. narked other than "natural event, the Medical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  Machinist		16b. Kind of Busin	ess/Industry				
215-0 e filed w tal Hygic ked othe nt, the N	Be Co		ne (First, Middle, M yn A. Ba	Maiden Surname) adur					
MD 21; 2 should b th and Men 27 is marl	To E	19a. Informant's Name/Relationship (Type, Print)  Kathryn A. McGee/Sister  19b. Mailing Address (Street and Number of 116 Allan Avenue, Vi	r Rural Route Nun		State, Zip Code)				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		4 Donation 5 Other Specify: Memorial Park 20	ne 2,	20c. Location - Cit	, MD				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	n Street	Elkton,	MD 21921 Approximate Interval				
Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):			Between Onset and Death				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated							
execut an and al - tra	ical Exa	events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  AMENDED							
	Wed	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	nancy	23d. Date of del Month	ivery Day Year				
i, P.O. E	ā	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			e to the cause of death?  Probably 4  Unknown				
of Vital Records, ag Physician: The law requirement the this certificate has been shered director, page 2 should be	Completed				e autopsy findings available to completion of cause of h? Yes 2 No				
tal Rection: The certificate ector, page	Bec	25. Was case referred to medical examiner?							
bysic al dire	리	1 Yes 2 No Indianation 2 ER/Outpatient 3 DOA VIIII Nurs		Residence 6 🗸	Other: Scene				
sion of trending I death. ctor: Afte	ation:	27. Manner of Death  1 V Natural 5 Pending   28a. Date of Injury (Month, Day, Year)   28b. Time of Injury   28c. Injury at Work?  1 Yes 2 No		how injury occurred					
Division Hospital or Attendia 24 hours after death. Funeral Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S or Town, S		r Rural Route Number, City				
To the Ho within 24 F To the Fu completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, ar one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		and place, and due	to the cause(s)				
	Σ	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed May 29, 2011					
		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore. MI	D 21223					
St	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature							

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day DORIS May 201 ETTEEN JONES 20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Colaine Drive Harford <u>Aberdeen</u> Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min Country) **Director** 519-44-6682 69 Idaho Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Colaine Drive 21001 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Secretary</u> College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alfred J. Quinton Ella Teresa Sorenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 Craig R. Jones (Son) Colaine Drive Aberdeen. 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 X Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 11, cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Fielding Mem. Cem. 2011 Idaho Falls, Idaho 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ de Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Month Day Year 1 Yes 2 L 9 Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 D-No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year,

State Registrar

DHMH 17 Rev 7/2009

CITW, MARPHA-1

rar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAV, D

31. Date filed (Month, Day, Ye

JUNE 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Keselman Physician/ 4:45a M aregory 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 9. Birthplace (State or Foreign Country) Ukraine Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 🕅 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 415-71-2526 80 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1400 Fenwick Lane, #1014 20910 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5** + Mathematician Education and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Motel Keselman Ides Kofman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alla G. Keselman - Daughter 10649 Montrose Avenue, Apt. 2A, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 05/22/2011 | Olney, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. disease Immediate Cause (Final Onset and Death arter Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transil The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day Year Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performe 2 X N To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af

Completed filled in by the fu 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Virginia Colliver, M.D.,

31. Date filed (Month, Day, Year)

Baltimore,

Box 68760

Records,

Division of Vital

Registrar's Signatu

6410 Rockledge Drive, #200, Bethesda, Maryland 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) :00PM Physician/ 201 ندا Medical 4c. County of Death 4h City Town Facility Name (if not institution, give street and number **Examiner** Baltimore zlen Date of Birth (Month, Day, eb. 26 9. Birthplace (State or Foreign Country) Massachusetts If Under 1 Year If Under 24 Hrs . Age (In yrs, last birthday) Social Security Number Funeral Months Days Hours 1 🔀 M 2 🗆 F . 1918 93 Yrs Director 024-07-6877 Usual Residence of Decedent 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director Severna Park 1 Tyes 2 No Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 358 Dun Robbin Drive 21146 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Engineering Engineer 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Julia Krol Albert Karzmarczyk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Arnold, MD 21012 287 Yale Court Joan Ott / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Lakemont Memorial Gardens 19 201 1 X Burial 2 Cremation 3 Removal from State May Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician Medical (or as a consequence of): Examiner Dheumon ration Sequentially list conditions, or as a consequence of Examine if any, leading to immedicause. Enter Underlying cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 2 No 1 Yes certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ဂ္ 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation Accident the 1 24 hours after deat 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide in by t determined filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of <u> న</u>0 HospiTa MAY 182011 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15, Day 2011 Year 8:29 A M Mary George Kalos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** New York Hours Min. 1 K M 2 🗆 F 053-24-3541 84 TT/11/1926 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo 1 Yes 2 X XNo Maryland| Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a #813 8600 Mike Shapiro Drive 20735 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 KNNo Yes, Give "natural", or 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12th College (1-4 or 5+) Contractor Olympic Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Koklas Katina Mirali 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Andrew Kalos / Son 4824 River Valley Way Bowie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State Resurrection Cem. 4 Donation 5 Other (Specify) 05/20/2011 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CORONARY ARTERY DISEASE disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) CHRONIC RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4√X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 24 N 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 K XNo Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Fywithin 24 hours after death.
To the Funeral Director; After (Month, Day, Year) 1 KNatural 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Pragtioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 16

Registrar
DHMH 17 Rev 7/2009

State

30. Name and add s of p

31. Date filed (Month

Roy Leiboff

MD

23a) (Type, Print)

10403 Hospital Dr. #102 Clinton, MD

20735

ompleted cause of death (Ite

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month Physician/ 18 2011 JAMES EARL KEGLEY 9:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7215 Blue Mountain Road Thurmont Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Sept. 21. 1943 1 X M 2 D F Hours Min. 220-40-0323 Virginia **Director** 67 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 🗌 Yes 2 😾 No Thurmont 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7215 Blue Mountain Road 21788 U.S.A. or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Refrigeration Mechanic U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James William Kegley Helen Faulkner permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangeline Kegley / Wife 7215 Blue Mountain Road, Thurmont, MD 21788 injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Blue Ridge Cemetery 5/21/2011 Thurmont, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lensee RÖBERT E ATTLEY & SON FUNERAL HOMES any 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician arconoma disease or condition MC-1 Medical resulting in death) Due to (or as a consequence of): L Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Directs for as a consequence of physician and the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No detached for 5 Other (specify) Month Day Pregnant at time of death 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 24 hours after death.

To the Funeral Director: After this To the

10

State Registrar

only one) 29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200PER

M.D.

32. Registrar's Signature

52 WATER

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

00228

(HURMONT

2 Medical Examiner: On the basis or examination arrovor investigation, in my opinion, weather the state and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Menth 23 2011 22:10 PM Catherine K. Kirkpatrick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cecil Elkton Care Rehab. E1kton Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 - M 2X Days Months Hours Min July 94, Yel 920 213-18-3710 90 Yrs Director Rising Sun. MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Cecil 1 Price Drive Elkton, MD 21921 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? r items 23a or iner must be r Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Price Drive 21921 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ŏ Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Specify: White 'natural" ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clyde Keilholtz Elsie Garvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 488 Hopewell Road Cathy R. Lewis Rising Sun, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 19406 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place ☐ Donation 5 ☐ Other (Specify) King of Prussia, PA 5/31/2011 Cremation Society of Pa 22. Name and Address of Facility Auer Cremation Services of Pa., ignature of Funeral Service Licensee 4100 Jonestown Road Harrisburg, Pa 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ediate Cause (Final Onset and Death Ph\_sician/ dise or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 4 Pregnant g Unknown Month Day Year Other (specify) Pregnant at time of death 2 X No g Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes writis Neck 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify, Hospital: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year SHAHNAWAZ KHAN D0062190 SHAHNAWAZ

Registrar DHMH 17 Rev 7/2009

State

MAN HW, SUITEA, CHESAPENCE CITY, MD 21915

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUGU STINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ May 19 2011 12:40 A Rosalyn Leah MALAKOFF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda <u>Suburban Hospital</u> 8. Date of Birth (Month, Day, Year Oct. 5. 1 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** New York Days Hours Months 91 115-07-7951 Director 1919 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Bethesda Montgomery Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20814 4925 Battery Lane #401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 

1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ YNo Specify. white Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
Maryland National (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Capital Park & Planning Secretary 18. Mother's Name (First, Middle, Malden Surname) Be 17. Father's Name (First, Middle, Last) and Mental F Minnie Provolsky ပ William Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8022 Maple Avenue, Takoma Park, MD item 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Walter Malakoff, Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lebanon Cemetery 05/22/2011 Adelphi, MD 21. Signature of June al Sevice Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory area. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiac Disease disease or condition resulting in death) Medical Examiner Atrial\_Fibrillation with Rapid Ventricular Response Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) and I-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 00 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 X No Day Z Pregnant at time of death 1 Yes 2 Unknown 9 Unknown 3 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 H Unknown Alzheimer's Dementia, Urinary Tract Infection Records, 24b. Were autopsy findings available prior to completion of cause of death? 7 Polymyalgia Rheumatica, Diabetes Mellitus 24a Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Yes  $\lesssim$ of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 0 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical P Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D\$\$68160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAY 23 2011

Box

20814

Kimberly Zuzak, M.D., 8600 Old Georgetown Road, Bethesda, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 May 2047 James Robert McClure Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min Mar 24 1 X M 2 □ F Months Days Hours 1921 Alabama Director 418-14-3138 90 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2X No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 189 Holly Oak Lane 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black White etc. ò 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 1956-60 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than " United States Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Naval Academy 12th 0 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert McClure Lula Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 Department of Health Important; If item 27 any injury or other tr Clara McClure(Wife) 189 Holly Oak Lane Annapolis, Md. 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran 5-20-11 21. Signature of Funeral Service Licenses Wmame Reas Seof RecilitSons Mortuary, P.A. Larr 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition Onset and Death Physician, Medical resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 use as IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Pregnant at time of death 2 No the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, The law requires Completed 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate of Vital or Attending Physician: director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Division 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and httle of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

MAY 182011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene John Edward Martin 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 25, 2011 1106 hrs **Medical Examiner** Edward Martin 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 6909 Jarrett Avenue Oxon Hill Prince George's If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 214-48-5097 1 X M 2 F 12/22/1947 South Dakota Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Maryland Prince George's or 28a-f shnv Oxon Hill Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shu
injury or other transmite event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e, Street and Number 10f, Zip Code 6909 Jarrett Avenue 20745 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1XX Never Married 2 Married 1XX Yes 2 No Specify: White If Yes, Giva Yaar Vietnam 1 Yes 2XX No specify: 3 Widowed 4 Divorced ੬ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 years Steel Worker Con 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ralph Edward Martin Nedra Be Jane Johnson 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ Susan Martin / Sister 165 Moffitt Street San Francisco, CA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 05/30/2011 Kalas Crematory Edgewater, Maryland Donation 5 Other Specify: 22. Name and Address of Facility George P. Kalas Funeral Home, P.A 21. Signeture of Funeral Service Licenses vin 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a Left Basal Ganglia Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease Of Highly that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical AMENDED 23a, pt. II, 27, per me, g916 6-16-11 sm X UNPENDED signed by the attending physician be detached for use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Fatty Liver Completed Division of Vital Records, certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? ✓ Yes 2 No death? 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes After 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending I Directur: 2 \_\_\_ Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 26, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PASHKEVICH MOULTON MAY 2011 12:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5604 SKATE COURT CHARLES WALDORF 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 □ M 2🗓 F Months Days Hours Min 235-24-6329 87 1923 Director PENNSYLVANTA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23° ---- any injury or other traumatic event, the Marianal once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes XX No CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5604 SKATE COURT 20603 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: WHITE 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BUDGET OFFICER U. S. GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CONSTANCE PASHKEVICH ANNA PETRANIUK 19a. Informant's Name/Relationship (Type, PrirDAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PEGGY MOULTON-ABBOTT 933 KELA CRESCENT VIRGINIA BEACH, VA 23451 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST.PAUL'S CH.CEM. 20a. Method of Disposition 20c. Location - City or Town, State JUNE te 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 6, 2011 4 ☐ Donation 5 ☐ Other (Specify) WALDORF, MD 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Signature of Funeral Service I on M00641 WASHINGTON AVE. LA PLATA MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ANCEN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practione by knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the bee Signature and title of certifier 29c. Lic 29d. Date signed (Month, Day, address of vers death (Hem 23a) (Type, Print n who co

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MICHAEL 2011 KEITH MULLINAX 1844PM Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Regional medical 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. MAR . 30, Yell 958 WASHT DC Director 53 216-70-9212 Usual Residence of Decedent permit. Page 1 and 2 should be filed wirthin 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked alth than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director CHARLES WALDORF 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8135 CEDAR RUN 20603 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) ELEVATOR MECHANIC SCHINDLER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM RALPH MULLINAX RENA FERN CORNETT i. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CEDAR RUN WALDORF, SPOUSE 8135 MARYLAND 20603 LISA M. MULLINAX / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JUNE™ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEM. 4, 2011 CLINTON, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, Jas M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician ACUTE INFERIUR MYOLARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or) Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Dav Year s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 8c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending work?
1 \sum Yes 2 \sum No Accident Investigation within 24 hours after deatl To the Funeral Director: completed filled in by the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

21501

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

E. Corral St

32. Registrar's Signature

Chodnida

31. Date filed (Month, Day, Year)

Lennis

DK

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and Mental Hertificate of Death	Reg. No.
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)  Anne C. Miller	2. Date of I Month May	18 2011 9:30A M
	Examin	_	4a. Facility Name (If not institution, give street and number) 3258 Geranium Court	4b. City, Town, or Location of Death  Adamstown	4c. County of Death Frederick
	Funeral Director		5. Social Security Number 1.56-20-6135 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birthda) 83 Yrs.	Months Days Hours Min (Month, I	9. Birthplace (State or Foreign Country) Pennsylvania
	ryland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or U		10d. Inside City Limits 1 ☐ Yes 2 [X] No
	the Ma	Funeral Director	MD. Frederick Adams	10f. Zip Code	10g. Citizen of What Country?
	ath with	ral DI	3258 Geranium Court	21710	United States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Modical Eventinal must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:	No-  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) omemaker	16b. Kind of Business/Industry  Own Home
land 2	2 should be filed within and Mental Hygiene. Is marked othar than aumatic avant, the Ma	To Be Co	17. Father's Name (First, Middle, Last)  Stephen Stash	18. Mother's Name (First, Midde Anna Zinga	
Mary	id 2 should th and Men 27 Is marke traumatic			ling Address (Street and Number or Rural Route Num 22 Cliftons Point St., F	ober, City or Town, State, Zip Code) Potomac Falls, VA. 20165
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra once.		20a. Method of Disposition 20b. Place of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cr	consition (Name of ematory or other place)  inity Cem. 5/23/11	20c. Location - City or Town, State  Bear Creek, PA.
Balti	permit. Departm Importa any inju			22. Name and Address of Facility Muriel H. Barber Funer P. O. Box 5038, Layto	ral Home
	11.11	5 0	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac or respiratory	r arrest, Approximate Interval Between Onset and Death
1	Pnysician /Medical Examiner		disease or condition resulting in death)  a	tre Vescular Disease	
		cal Examiner	Sequentially list conditions, if any, leading to immediate the first section of the control of t		
,092	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		that initiated events resulting in death) Last  C.  Due to (or as a consequence of):		
Вох 68	certificat nding phy use as th		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. B	that the death ned by the atter detached for u	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year
	requires tha been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the Hypertension		d tobacco use contribute to the cause of death?  ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Il Records,		Completed		pe	24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \sum_{Yes} 2 \sum_{No} \]  1 \[ \sum_{Yes} 2 \sum_{No} \]
Vital	Physician: r this certifical ral director, partition	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	26. Place of Death (Check on ent 3 DOA Other: 4 Nursing Home 5 🖔 R	
on of	ding h. Aftel fune		27. Manner of Death 1 S Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28d. Describ	ne how injury occurred
Division of	Il or attending after death. I Director After din by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office 28f. Location	n (Street and Number or Rural Route Number, Town, State)
	To the Hospital or intending Ph within 24 hours after death. To the Funeral Director After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1 ☑ Certifying Physicien: To the best of my knowledge, der (Check only one)  1 ☑ Certifying Physicien: To the best of my knowledge, der (Check only one)		e, date and place, and due to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier M D	29c. License number  \$\mathbb{D} \cdot 0 \cdot 5 8 \ 7 \ 2 \ \cdot 6	29d. Date signed (Month, Day, Year)  5 - 18 - 11
	10		30. Name and address person who completed cause of death (Item 23a) (Typ 3000 - D Ventre Ct. Mycss	e, Print) Yvette M.L. Warren,	M.D.
	Sta Regist		30. Name and address & person who completed cause of death (Item 23a) (Typ 3000 - D Ventrie Ct. Myerson 31. Date filed (Month, Day, Year)  MAY 20 2011  32. Registrar's Signature	pare	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ARKER Physician/ 0124 \_10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 131 S. MEADOW DR. ANNE ARUNDEL GLEN BURNIE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last hirthday) **Funeral** Hours 1 🗆 M 2 🖳 04/07/1921 MARYLAND Director 215-24-3904 90 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 USA 131 S. MEADOW DR. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM THOMAS BELT ALICE ALBERTA GAMBRILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRY D. PARKER SR./SON 131 S. MEADOW DR., GLEN BURNIE, MD 21060 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BESTGATE MEMORIAL 4 Donation 5 Other (Specify) 05/20/2011 ANNAPOLIS, MD 21. Signature of Funeral Service Lic 22. Name and Address of Facility HELFENBEIN & NEWN part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ N disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month Month Day Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ABETES 1 Yes 2 No 3 Probably 4 Unknown ERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autonsy 1 Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 100 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Micro Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License number 0 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HWY. DGHTFOOT TAYLOR Date filed (Month, Day)

State

Registrar

182011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mavonth17, Physician/ 29911 Wilma Irene Polvinale 1:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Solomons Calvert Solomons Nursing Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F 90 07/12/1920 Director 579-14-4798 Carolina Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Upper Marlboro Marvland Prince George's 1 Yes 2 K XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 8060 Croom Road 20772 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 K NNc 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2xXNo Specify: SpecifWhite Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee gonee. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker In Home 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Minnie Mae Robinson Knighten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 8060 Croom Road Upper Marlboro, Maryland Dorothy T. Principe / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Kalas Crematory Edgewater, Maryland 5/18/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licensee 22. Name and Address of Facilingeorge P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 ard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between 15 years Immediate Cause (Final Physician. Atherosclerosis disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or it that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Yes 2 X No the 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 H Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate It 1 ☐ Yes 2 ☐ No filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 은 1 Inpatient 2 I ER/Outpatient 3 DOA 4XX Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕱 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1XX certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D0031563 May 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 20945 Great Mills Rd. #203 Lexington Park, MD Charles M. Benner,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 182011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Buddhisagar I. Patel 2011 Medical Mav 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10 Keystone Drive Gaithersburg Montgomery 7. Age (In. vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Davs Hours April 14, 1939 Director India 020-68-1734 72 Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Gaithersburg 1 Tyes 2 No Marvland 1 4 1 Montgomery 10e. Street and Number Ь 10f. Zip Code 10g. Citizen of What Country? pe i ms 23a must be Funeral 20878 USA 10 Keystone Drive items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 6 þ 1 Never Married 2 X Married ☐ Yes 2 🏋 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Hiraben Patel Tshverbhai Patel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bhikhiben Patel-WIFE 10 Keystone Drive, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Baltimore Washington Crem May 18, 2011 Laurel, Maryland Signature of Funera Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, Inc.
7601 Sandy Spring Rd., Laurel, Maryland 20707 Wa MO123 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Retween Bladber concer Onset and Death Immediate Cause (Final disease or condition Metastate Ph\_sician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death signed by the a 2 No 1 Yes 2 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h performed Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) washingto , De

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 192011

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	Funeral Director		5. Social Security Number 161–20–4726	6. Sex 1 <b>X</b> ) M 2 □ F	7. Age (In yrs. 83	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1927	Col	thplace (State or Foreign untry) unsylvania	
	and show	ō	Usual Residence of Decedent  10a. State 10b. County		10c. C	City, Town or Lo	ocation					10d. Inside City Limits	
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Division of Vital Records,	ttending F death. stor: After / the funer.	Certificate	1 Natural 5 Pendin 2 Accident Investig	9 1 1-	of injury h, Day, Year)	28b. Time o injury	work		28d. Describe ho	w injury occur KE (	red	NI FOM	b
VISIC	or Atte	Sertif	3 ☐ Suicide 6 ☐ Could at 4 ☐ Homicide determine	not be	of Injury - At I	-	reet, factory, office	5	28f. Location (St City or Town	reet and Numb	er or Ru	ral Route Number,	EN
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							cause(s) and manner stated.						
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	10+1		30. Name and address of person v	vho completed cause	of death (Ite	m 23a) (Type, I		ν Ψ -	* 12	J		/ /	1
	V,6		31. Date filed (Month, Day, Year)	DES 1	egistrar's Sign	105 lature	DIC	1174	LDF	2, L1	N	THICV	41
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ Ker erome Ma Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number, **Examiner** 20 Prince Calvert Freder YCK . i) ares If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Country) Days Min. July 15. 1938 1 🔜 M 2 🗌 F 72 Director 215-36-5662 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Prince Frederick MD Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20678 420 W. Dares Beach Road Apt. #201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Forces?.
1 ☐ Yes 2 ☐ No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Black Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Plumbing Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Artena Sewell ပ Horace Parker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 990 Dares Beach Road, Prince Frederick, MD 20678 19a. Informant's Name/Relationship (Type, Print) Ernest A. Sewell - uncle 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Alexandria, VA Metropolitan Crematory May 27, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence g if any, leading to immediate cause. Enter Underlying After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death g Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of injury (Month, Day, Year) 28c. Injury at wo<u>r</u>k? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation after deat within 24 hours after death

To the Funeral Director: A

completed filled in by the it 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rince Trea ar ohn 2. Registrar's Sign 31. Date filed (Month, Day, Year) State 8 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:50 A 2 Date of Death Physician/ May th 21, 2011 Milton Samuel RUTSTEIN Medical 4a. Facility Name (if not institution, give street and number) County of Death Montgomery 4b. City, Town, or Location of Death Examiner Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Sept. 27 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 🔀 M 2 🗆 F 88 029-09-1754 Yrs. **Director** 1922 Massachusetts Sept Usual Residence of Decedent filed within 72 nous and tall Hygiene.
tal Hygiene.
ed other than "natural", or items 23a or 28a-f show
e other, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Potomac Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20854 11512 Gainsborough Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 📈 No Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify: white If Yes Give 1 ☐ Yes 2 X No Specify: Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation National Oceanographic (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) & Atmospheric Admin. Oceanographer other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame)
Bessie Patoshnik 17. Father's Name (First, Middle, Last) and Mental Fis marked o မ Nathan Rutstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 7621 Fontaine Street, Potomac, MD Eli Rutstein, Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 05/2272011 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Clarksburg, MD Other (Specify) Garden of Remembrance Memorial Park Signature of Funeral Service Licenses 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 20012 Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ischemic Cardiomyopathy Physician/ Medical Due to (or as a consequence of) Examîner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Last Due to (or as a consequence of): Examir Atrial Fibrillation Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Peripheral Vascular Disease Records, 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Diabetes Mellitus has e 2 autonsy page performed? Yes 21 No death? Tobacco Abuse 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medica of Vital director, 26. Place of Death (Check only one) Be 2 No Other: 1 Yes မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completed filled in by the funera 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident injury 5 Pending Division 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) DAA 68167 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD Kimberly Beth Zuzak, M.D., 31. Date filed (Month, Day, Year) State MAY 23 2011

Registrar

MILTON

RUTSTEIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen D. Reese May 2011 10:40 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖔 F Months Hours Min. Mary land **Director** 718-09-0987 84 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 930 Astern Way USA 21401 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black. White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 ♥ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12th Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ൧ William Otto Klemm Ada Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 317 Bay Drive, Stevensville, Maryland 21666 William D. Reese/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Doration 5 Other (Specify)
21. Signature of Juneral Service Licensee Kalas Crematory 5/20/11 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardio myonathy disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires in 24 hours after death.
Funeral Director: After this certificate has been sign Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🔀 No မ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 🔀 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2/11/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and (tem 23a) (Type, Print) 2001 Medical Pankway annapolis, typ

State Registrar

P.O.

Division of Vital

DHMH 17 Rev 7/2009

31. Date filed (Mo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Pay 2**0**11 Patricia Dooley 6:55 P Richardson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 640 Teton Ct. Lothian 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours Min. 1071671934 Washington DC 579-42-3615 Director 76 Yrs Usual Residence of Decedent or 28a-f show notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Lothian 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 20711 604 Teton Ct. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 3 X Widowed 4 Divorced Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Means injury or other traumatic event, the Means Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nelson Burke Dooley Maude Adrian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Richardson 640 Teton Ct. Lothian, MD 20711 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Atlantic Crematory 5/18/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 85 vice Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 905 Galesville Rd, Galesville, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown that the death Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate 1 Yes 2 No Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 Yes 2 70 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Aatural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie 29b. Signature and title of certifie 80 D58166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Suite 250 Edgauster Broverton

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:05 PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) March 5, 1947 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 X F Pennsylvania 64 211-34-5591 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Bowie 20715 12413 Shelter Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 🕅 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ <u>Social Worker</u> Health & Social Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Ann Tunella Carl Anthony Roman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traum once. 12413 Shelter Lane Bowie, MD 20715 Robert L. Howe/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Db. Place of Disposition (Native Science)
Arlington National unk

Arlington, VA

22. Name and Address of Facility Robert E. Evans Funeral Home 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Final Service Licenses 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown ate has been sign page 2 should b 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Pending investigation Injury s after death. 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760 P.O. Division of Vital Records, 24 hours within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tittar 31. Date filed (Month, Day, Year State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

170200

MD

and manner stated.

back

600 North Wolfe St, Baltimore, MD, 21287

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year ROWLAND LARRY 1:20 AM MA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTMORE OF MARYLAND UNIVERS 174 MEDICAL (M 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Sept. 4, 1942 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ∏ M 2 □ F California **Director** 433-58-4419 68 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Ex miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7521 Woodbine Drive. IISA 20707 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Year or Dates. 59-67 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 
Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Electronics Sales and Marketing Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Elaine Rasmussen Herman John Rowland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7521 Woodbine Drive, Laurel, Maryland 20707 Annabelle Rowland-Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory May 17, 2011 Glen Burnie, Maryland 21. Signature of Funera Service Licensee 22 Name and Address of Facility Fleck Funeral Home, Inc. M01234 7601 Sandy Spring Rd., Laurel, Maryland 20707 23a. Part 1. Enter the dijease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician MULTISYSTEN ORGAN FAILUR Medical Medical Examiner resulting in death) Due to (or as a consequence of): Pulunonins ASPIRATION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine C 844 Cause (Disease or iinjury that initiated events resulting in death) Last tor. After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit Compulypour OF SUCCEME Due to (or as a consequence of): Physician/Medical NA MORBID osesir Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes To the Hospital or Attending Physician: 'within 24 hours, fler decth.

To the Funeral Director: After this certifics 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1 🚣 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, duality countries at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier D6-6562 MD 15 th 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTMON, MA ZIZOI: Runald Tesoriero SCUTTA GREENE STRET

Registrar

gistrar's Signature

2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland / De	partme ertifica			ind M		giene	Manage Ma	18254
			1. Decedent's Name (First, Middle, La	st)						2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Martha P.	Rice						May		11	01:48A M
	Examin		4a. Facility Name (If not institution, giv.	e street and number)		4b. City	, Town, or	Location of	f Death		4c. County	of Death	
			College View Ce	nter			Fred	lerick	ζ		Fr	eder	rick
	Funeral		5. Social Security Number 6. S		e (In yrs. last birtho		er 1 Year	If Under 2		8. Date of Birt	h Vansi	9. Birth	place (State or Foreign
	Director		217-42-1335	☐M 2 <b>⊠</b> F	67 Yrs	Months	Days	Hours	Min.	(Month, Da) Sept.	4 1943	Vi	rginia
			Usual Residence of Decedent										
	ylan		10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits
	Mar	to	MD. Frede	rick	Fred	erick							1 □ Yes 2 ⊠No
	288	rec	10e. Street and Number			10f. Z	ip Code				10g. Citizen of W	/hat Cou	untry?
	3a o	٥	281 Pinoak Road				21	701			United	1 St	ates
	hours after death with the Maryland tural, or Items 23a or 28a-f show at Exact, art must be rediffed at	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	3. Was Dec	edent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	- 14. Race		ican Indian,
10	ter c	-un-	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🗷	No	If Yes, sp	ecify Cuba	n, Mexican	, Puerto	Rican, etc.)	1	k, White	
36	irs al	by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔁 No	Specify:			Specify	· Wh	ite
21215-0036	tura stura		15. Decedent's E	ducation	16a. De	ecedent's Us	ual Occupa	ation			16b. Kind of Bu	siness/li	ndustry
15	in 72	ojet	(Specify only highest gra	ide completed)	(G	ive kind of w e. DO NOT	ork done d use retired	during most I)	of worki	ng			
12	with than	Completed	Elementary/Secondary (0-12)	College (1-4or	D+)	Master	Sado	dler			Harness	s/Sa	ddle Maker
	1 and 2 should be filed within 72 hours Health and Mental Hygiene. em 27 is marked other than "natural"; ither traumatic event, Tre Medical Exa	ŭ	17. Father's Name (First, Middle, Last,	)				18. Mother	r's Name	(First, Middle,	Maiden Surnam		
an	d be	) Be	Robert Michie					Fra	ance	s Hodg	es		
$\geq$	d Me d Me mark matic	<sup>2</sup>	19a. Informant's Name/Relationship (	Tuna Print)	10h M	ailina Addro	oc /Stroot				er, City or Town,	State 7	in Code)
Maryland	12 s h an 7 ls r traus		Melinda Rice Mos			-							
	tealt im 2			ss/Daugnte						Date	New York		2567
0	ges 1 of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Di cemetery,	crematory or	other plac	e)				•	
<u>E</u>	Pag meni ant: ury		`4 □Donation 5 □ Other (Specif	y)	Metrop	olitar	Cre	n. !	5/1	8/11	Alexa	andr	ia, VA.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any figury or other traumatic event, the Medical Examinat must be realthed at once.		21. Signature of Funeral Service Licer	1500		22. Name a	and Addres	s of Facility	rher	Funera	1 Home		
m	89789		Xojw.	Saule	1						sville,	Md.	20882
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not								Approximate Interval Between
	Physician	0 1	Immediate Cause (Final		n (ante								Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence of):							-	
	Examiner			Due to (or as	a consequence on.								
		<u>~</u>	Sequentially list conditions,	b. Due to (or as	a consequence of):							-	
	ted	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury										
	and and	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):			_				_	
8760,	cien cien curia			232.15 (5. 45	2 00.100420.100 01/1								
87	eath certificate be executed attending physicien and for use as the burial-transit	Physician/Medical		_ d									
9	entific ling p	₩ M	IF FEMALE:	00 4									
Вох	death co	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐Ectopic	pregnancy				23d. Dat Mor		very Day Year
	0 0	sici	1 ☐ Yes 2 ☑ No	4☐Pregnant a 9☐Unknown	t time of death	5 Other (	specify)						
P.0	that the de led by the a detached t	hy	9 □ Unknown		_					-			
	w requires that the been signed by the should be detache	by F	Part II. Other significant conditions of	contributing to death b	out not resulting in th	e underlying	cause give	en in Part I.		23e. Did to	obacco use contr	ibute to	the cause of death?
5	quire on sig uld b	be								1 🗆 1	res 2 DNo	3 Pro	bably 4 Unknown
Records,	2 0 %	Completed								24a. Was	an 24b. V	Nere aut	topsy findings available
Re	0 = 0	ш			<del></del>						rmed?	death?	ompletion of cause of
a	iclan: The certificate rector, pag	ပိ	25. Was case referred to medical							1 Yes		Yes	2 No
Vital	sicia certi recto	00	examiner?	Hospital:			Oth	or	_	(Check only o			
of	Physician: this certifical	To.	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 🗆 Inpati			DOA	4			dence 6 Other		eify)
_		Certification:	1 Tratural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) Zob. Tim	ry	28c. Injun Worl			Zou. Describe i	low injury occur	θu	
Division	Attanding r death. actor: After y the fune	cat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b			М		Yes 2□N					
$\geq$	or At ifter d Diract in by	Ħ.	4 Homicide determined	286. Place of In	jury - At home, farm tc. <i>(Specify)</i>	, street, facto	ory, office		- 1	28t. Location (3 City or Tox		ar or Hui	ral Route Number,
		S											
	Hospital 14 hours a Funaral I	cai	29a. Certifier 1 Certifying Pt	nysician: To the best miner: On the basis of	of my knowledge, d	eath occurre	d at the tin	ne, date and	d place, a	and due to the	cause(s) and ma	nner as	stated.
	the Fin 24	Medical	one)	and manner st									
	To the within 2 To the comple	₹	29b. Signature and title of certifier			2	9c. License	e number			29d. Date signed	1	
			1 Vec	MD		7	>60	417			5/17	120	7 [)
			30. Name and address of person who	completed cause of	ieath (Item 23a) (Ty	pe, Print)		. , ,					
	7		Hemen shah	45 C	Thomas	Toh	nsov	1 Di	1	Frede	NICK.	MD	21702
/	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	death (Item 23a) (Ty Thomas rar's Signature	200	1		-				
	Registr		MAY 20	2011 Den	we p.	1 go and							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Walter L. Sturdivant. 9:00p M Jr. 2011 May 18. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Hours Min North Carolina Director 579-40-2751 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director Silver Spring 1 Yes 2 X No Maryland Montaomeru 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 U.S.A. 13229 Glenhill Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Sprican-American 1 Never Married 2 X Married "natural", or þ within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 1959 Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Central Intelligence (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Management Analyst Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Walter L. Sturdivant, Sr. Nezzie Lules 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trausonce. 13229 Glenhill Road, Silver Spring, Maryland 20904 Lottie W. Sturdivant - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 05/25/2011 Brentwood, Maryland Signature of Funeral Service Lic 22. Name and Address of Facility Hines-Rinaldi Functul Home, Inc. Neva M. 11800 New Hampshire Ave., Silver Spring, MD 20904 M01621 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ Prostate Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No 2 🗌 No Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: Hospice 입 Nursing Home 5 Residence 6 🛚 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 5 Pending 2 🗌 No death within 24 hours after death

To the Funeral Director: / Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10 10 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Debrah Miller,

MAY 23 2011

CRNP

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 19, 2011 Sanzaro Katherine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6905 Forest Hill Drive University Park P.G. 8. Date of Birth
(Month, Day, Year)
Oct. 23, 1 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours Country) 215-50-1074 57 **Director** Oct. Usual Residence of Decedent 28a-f show 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD P.G. University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6905 Forest Hill Drive 20782 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.] Black, White, etc. ğ 1 Never Married 2 Married Yes 2 No 21215-0036 72 hours after White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Physician Health Care and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Frank J. Sanzaro Patricia A. Woodworth 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine M. Woodworth/Aunt 4203-A Woodberry Street, University Park, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 X Burial 2 Cremation 3 Removal from State May 24 2011 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ <u>Urosepsis</u> disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Multiple Sclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and Il-thansit Congestive Heart Failure that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 \( \sum \) Yes \( 2 \sum \) No Month Pregnant at time of death 1 ☐ Yes ∠ E 9 ☐ Unknown 9 Unknown is been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 t has performed? Hospital or Attending Physician: The certificate Yes 2X No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes XX No ဂ္ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred vithin 24 hours after death.

to the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 X Natural 5 Pending work' 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 10 29b. Signature 29d. Date signed (Month, Day, Year) MD52247 May 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Collin Cullen, MD 7625 Wisconsin Avenue, Bethesda, MD 20814

3. Time of Death

рм

2:57

D.C.

Approximate Interval Between Onset and Death

Day

2 No

Year

10d. Inside City Limits

1 Yes 2 No

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

MAY 23 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ASMEL ANTONIO SALINAS May 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL INSTITUTES OF HEALTH BETHESDA MONTGOMERY Social Security Number if Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country New York 1 🗶 M 2 🗆 F Months Hours (Month, Day **Director** 578-94-9181 36 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Eximiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No Maruland Montgomery Montgomery Village 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? by Funeral 20440 Meadow Pond Place 20886 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 🗷 Yes 2 □ No Specify: Salvadorian Specify: 3 Widowed 4 X Divorced Completed Caucasian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h th and Mental Hygiene. 27 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Quality Assurance Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Asmel Salinas Rosa Mirian Mendoza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is Rosalynn Salinas - Sister 1451 South Miami Ave.. #2808. Miami. Florida 33130 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗌 Burial 2 🔀 Cremation 3 🗎 Removal from State Lincoln Crematory 05/25/2011 Brentwood. Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ aastric cancer disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 1 Yes 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title, 29d. Date signed (Month, Day, Year) MP038520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melissa Alvar m. 10 CENTER DR RETHESDA MD 20892 31. Date filed (Month, Day, Year) State 53 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death May 17, Physician/ 2011 11:40 AM Margaret Arnold Sisson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Prince George's Collington Episcopal Life Care Center Mitchellville 5 Social Security Number 7 Age (In vrs last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Nov. 10, Year) 911 Marv Tand 99 Director 213-38-0279 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland must be notified at Director 1 Yes 2 X No Mitchellville Marylandl Prince George's 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral USA 20721 10450 Lottsford Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 9 ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 ☑ Widowed 4 ☐ Divorced White Page 1 and 2 should be filed within 72 hournment of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Helen Wright Prather Harry Scott Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Styler's Mill Crossing WIlliamsburg, VA 23188 David H. Sisson Sr,/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Washington 1 Burial 2 XCremation 3 Removal from State Department of Important: If any injury or 5/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Dementia Alzheimer's digecese set and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence f) Examiner eviatri weeks Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit that the death certificate be executed and resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant at time of death 1 ☐ Yes 2 ₹ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à osteoarthiris To the Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: Nursing Home 5 A Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h. Time of 28c. Injury at 13 Natural Accident 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Sign∦ture and title of ce/ti 29d. Date signed (Month, Day, Year) 00042049 2011

State Registrar Alain

MD

upper Marlboro, MD.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAMPALOUX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 19, Physician/ 2011 \_A <sup>M</sup> Ralph Squier 12:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Pay, 1 💢 M 2 🗆 F Min. Months Days Hours 80 Director 1930 Connécticut 040-24-0337 Usual Residence of Deceden an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Calvert 0wings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20736 1841 Bright Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces'
1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married δ 2 🗆 N Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Engineer Friction Materials 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Windfield Squier Doris Ridpath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau Brenda Squier/ Wife 1841 Bright Lane Owings, MD 20736 20b. Place of Disposition (Name of Baltimore Washington Crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/20/2011 4 ☐ Donation \_5 ☐ Other (Specify) Laurel, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final log Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Examine Due to (or se a nonesquarine cr): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day n signed by the a ld be detached fo 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 N 1 Tes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 2 No 1 Inpatient 2 ... ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No Pending Investigation completed filled in by the 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Light certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa 29d. Date signed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

State Registrar

G DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month.

Frmm

gistrar's Signat

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 1930 РМ Harvey Miller Steele Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Ceci1 E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** <sup>Yea</sup> 1921 Days Hours 1 🛛 M 2 🗆 F March 16. Maryland **Director** 90 215-14-4582 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any higury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 United States 258 Fair Hill Drive 12. Was Decedent Ever in U.S.
Armed Forces? World

1 X Yes 2 No
If Yes, Give War II 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Scott Steele Minnie D. Feehley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Steele/Wife 258 Fair Hill Drive, Elkton, MD 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 2011 R. A. Ferris & Co., Inc. West Chester, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ PROSTATE CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Li Felai Go. in the past 12 months? 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rosi lection 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? VENOUS THROMBOSIC 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accider iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

NARATANA

31. Date filed (Month, Day,

P. V-Noya

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V- PULA

RAS

126

29c. License number

E.HIGH

00065733

STREET, FLICT N. MD 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month May 18 201 Teal Physician/ 1020 A M F. Thrift Roberta Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Harwood Mandrin Hospice House g. Birthplace (State or Foreign Country) **p** Δ 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Days Months Hours 2/17/1919 PA 92 Director 204**-**05-1822 Usual Residence of Deceder 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a -f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City. Town or Location Director Crofton 1 Yes XX No Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21114 USA 1755 Carry Place Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Xiidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Administrative NASA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Myrtle Bull Ervin S. Yinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nephew Ken Yinger 1080 Elliott Lane York, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5/24/2011 West River, MD 4 Donation 5 Other (Specify) Our Lady of Sorrows Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ OSO Vas disease or condition / Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hyperknsior Dementia 1 🗌 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 XNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1X Natural 5 Pending 2 Accident 3 Suicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) 29b. Signature and title of 18, 2011 MD SP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Bowie, MD 20716 Konni E. Bringman 4201 Mitchellville Rd. 31. Date filed (Month, Day Registrar's Signatur 19 2011 State Registrar

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State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY Month DONNA Physician/ KAY TZAFAROGLOU 2011 3:00P M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES 210 MORGANS RIDGE COURT LA PLATA If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days Hours Min Country Months 1 □ M 2 🔀 F 212-98-6259 APR. MARYLAND 1965 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 72 hours after death with the Maryland Director 1 Yes 2x XNo MD CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code Funeral 210 MORGANS RIDGE COURT 20646 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2XXXIo Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event: the Manay injury or other traumatic event: the Manay College (1-4 or 5+) Elementary/Seconday (0-12) H.R.D.COMPENSATION MGR. WILLS GROUP Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS R. HILL CHARLOTTE ANN STONESTREET 19a. Informant's Name/Relationship (Type, Print) HUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTOPHER TZAFAROGLOU 210 MORGANS RIDGE COURT LA PLATA, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition JUNE<sup>Bate</sup> XXBurial 2 Cremation 3 Removal from State ST. MARY'S CEM. 3, 2011 NEWPORT, MARYLAND 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Dusito (or as a consequence of, Examine if any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or linjury and -trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria /Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death 9 Unknown the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performe 1 Yes 2 No certificate 1 Yes 2 X No or Attending Physician: after death.

Director: After this certifica director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 \(\sum \) Nursing Home \(\frac{\frexi\fir\f{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\ 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27, Manner of Death 28b. Time of 28d, Describe how injury occurred 28c. Injury at Certificate: injury 5  $\square$  Pending 1XXNatural 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifical Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature an 201 D27348 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWARD HAFT, M.D. 12070 OLD LINE CENTER WALDORF, MD 20602 31 Date filed (Month, Day, Year) State JUN 0 8 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HUNTER CHARLES VINSON MAY 2011 11:50AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth **Funeral X** M 2 □ Days Hours (Month, Day, Year) MARYLAND Director UNAVAILABLE 27,2011 MAYpermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2348 GUTRICK ROAD 20640 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc δ 1 X Never Married 2 ☐ Married Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည JOSHUA MARK VINSON HOLLY DEVIN TODER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLLY D. TODER / MOTHER 2348 GUTRICK ROAD INDIAN HEAD, MD 20640 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State JUNE ST. IGNATIUS CH.CEM 4 Donation 5 Other (Specify) HILL TOP, 2011 Signifur of Fungal Springe Licens 22. Name and Address of Facility WASHINGTON AVE FUNL SERVICE 20646 M00641 5635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hysician/ Moon disease or condition Medical resulting in death) Due to (or consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsv performed? Yes 2 No 1 Yes 2 No **Irector** After this certifical in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours fter death. 1 Natural 2 Accident 3 Suicide (Month, Day, Year) 5 Pending injury work?
1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number completed filled in by 4 Homicide determined building, etc. (Specify) To the Hospital within 24 hours
To the Funeral Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. None and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ Clifford Richard Vetter Month Рм 5:37 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Month, Day, Ye August 13, 1 X M 2 🗆 F 75 Months Hours 058-28-4477 New York 1935 Director Usual Residence of Decedent 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Frederick Maryland Frederick 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21703 United States of America 6441 Jefferson Pike Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11. Marital Status rmed Forces?

Yes 2 \( \sum\_{No} \) 1953-Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 1957 Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Officer Law Enforcement 12 Be permit. Page 1 and 2 should be fileo.
Department of Health and Mental Limportant: If item 27 is many injury or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Gertrude Epp Clifford Richard Vetter, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank J. Vetter / Son 9010 Harris Street, Frederick, Maryland 21704 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗌 Cremation 3 🗆 Removal from State Garrison Forrest Veterans May 24, 2011 Owings Mills, Maryland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licens 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death acteremia Immediate Cause (Final Physician/ Ston disease or condition Medical resulting in death) Due to (or a va consequence of) Examiner menmonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Month Dav Pregnant at time of death 2 No sate has been signed by the apage 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other} \( \text{Specify} \) Hospital မြ 1 npatient 2 ER/Outpatient 3 DOA . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🕱 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 5 MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7+45+ Frederick, MD 5+1VA Hee Nam 400 Myung 31. Date filed (Month, Day, Year) 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#29dperMD, 5/23/11; EMW, MoCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Barbara Wyvill 2011 9:52 May 14, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 10415 Rutland Place Hyattsville Months Days Hours Min. Dec. 104, Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 C **Funeral** 1 M 2 X F Year 936 598-48-7168 74 D.C. Director Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Hyattsville Maryland Prince Georges 1 Yes 2 No 10g\_Citizen of What Country? 10f. Zip Code 20783 0 10e. Street and Numbe ian "natural", or items 23a or Medical Examiner must be r 10415 Rutland Place Funeral within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. White δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates 3 Nidowed 4 Divorced Specify Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ıl Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be filed valued permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked ott
any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosie Lea Henley ပ္ Bishop Rawlings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10415 Rutland Place, Hyattsville, MD 20783 19a. Informant's Name/Relationship (Type, Print) Linda Lee Heizmann / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State 19, Мау 2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatur Francis J. Collins Funeral Home, Inc. 500 Univeristy Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Diabetes Mellitus, Type I Sequentially list conditions Examin cause. Enter Underlying attending physician and المرابعة as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Parkinson's Disease Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 🔀 the Hospital or Attending Physician: The 24 hours after death.

Funeral Director, After this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 🗌 Yes 2 XNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending 1 X Natural Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined cal 1逛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of cert 29c. License number 29d. Date signed (Manth, Day, Year) <del>1 5-</del>16-2011 77 33 and who completed cause of death (Item 23a) (Type, Print)
MD 10810 Hickory Ridge Road, Columbia, MD 21044 30. Name and address of parso Barry Lance, MD

State

Registrar

31. Date filed (Mor

Month, Day, Year) MAY 23 2011

Seles

. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ,20° James Augustus Waldron June Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** : WAKEDRON James AUG **Yoint** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Y
Sept. 19 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Year Country) 191 166-12-4720 Director 93 VA Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Bloxom VA Accomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23308 U.S.A. 16485 St. Thomas Road 12. Was Decedent Ever in U.S. Armed Forces?

1 No Yes 2 1946
Yes, Give 1947 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea gince. Aircraft Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Quality Engineer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Hankins Jesse L. Waldron Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16481 St. Thomas Rd. Bloxom, VA 23308 James D. Waldron/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cremation Direct
Service June 1 Burial 2 Cremation Removal from State 4 Donation 5 Other (Specify) 2011 York, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, 19 S. Main St., Stewartstown, PA 17363 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by þ ran 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law requires cate has been sig , page 2 should b Completed Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No this certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ည within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: Natural
Accident (Month, Day, Year) injury 5 Pending Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number PA State 29d. Date signed (Month, Day, Year) 29b. Signature

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ OMA Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, **Examiner** AShington Medical If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country) Funeral (Month, Day, Year) 74 Yrs. Months Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Funeral Director 1 Yes 2 No 10g, Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maide 17. Father's Name (First, Middle, Last) မ Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number 3 WEST MAYER DR. FINKSA DROMD-ZIO48 Baltimore, 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State DIENTON, MID. 4 Donation 5 Other (Specify) . Signa re o Funeral Service complications that caused the death. Do not enter the mode of dying, such as car Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Exam burial-transit and to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Yes 2 No the detached g 🗌 Unknown P.O. | cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown Records, 1 Tyes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No Yes Yes of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this Division completed filled in by the To the I

> 30. Name and address of person who completed strar's Signature State Registrar

Certifying Nurse Practioner to the best

29a. Certifier

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 7th 201T 1:35 PM Lucile C. Acton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number If Under 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Maryland 1<u>947</u> Days Hours Min. Oct. 5. Months 1 🗆 M 2 👽 F 213-48-0726 63 Director Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examples. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 46 Lambeth Bridge Court 21093 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Trivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Editor Magazines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilton S. Carter, Jr. Araminta Rullman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Carter / Brother 18 Glyndon Drive, Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/08/2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Allyson K Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 M Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural iniury work?
1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar only one)

Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CARROLL CARROLL WESTMINSTER Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Months Days Hours Min. 1 □ M 2XXI Mary I and Director 86 219-18-1665 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code Citizen of What Country? United States of America Funeral 3546 Basler Road 21074 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with n and Mental Hygien 7 is marked other th 9th Buyer Black & Decker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic Unknown Hilda Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip F. Auld (Husband) 3546 Basler Road, Hampstead, Maryland 21074 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ♣ Other (Specify) Entombment cemetery, crematory or other place) June 13, Druid Ridge Cemetery Pikesville, Maryland 2011 . Signature of Fun in Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. mali 3296 Charmil Drive, Manchester, Maryland 21102 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ESPIRATORY FAILURE disease or condition resulting in death) Medical Examiner LATERAL Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit HRONIC ATRIAL and resulting in death) Last attending physician for use as the burial Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificd completed filled in by the funeral director, I Division of Vital Hospital or Attending Physician: 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ER/Outpatient 3 DOA ၉ Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D44542 g 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANGANATHAN, MO 200 MEMORIAL NE WESTMINSTER, MD 2/157 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary P. Allocca June 2, 2011 6:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Charlestown Care Center Catonsville Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 😾 F 213-28-1583 Director June 5, 1928 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina. 10c. City, Town or Location 10d. inside City Limits 10a. State 1 ☐ Yes 2 ▼ No Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 713 Maiden Choice Lane #1409 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Rusiness/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Jones Margaret Cochran ပ 19a, informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Miller Daughter 7523 Greenwood Drive; Highland, MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 6/7/2011 □Donation 5 □ Other (Specify) Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. . Signature of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, 23a. Part Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between guermonia Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ate has page 2 s autopsy performed 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (term 23a) (Type Print) reden Chare Car

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $\underline{AM}^M$ 201 Dawn Denise Arnold 6:35 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F 1956 Director 54 Yrs. 216-74-8731 Nov Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 1 Yes 2X No Harford Darlington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 1417 Stafford Road 21034 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education unk 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 foos service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Robert William Prosser Shirley Margaret McCullough traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Jesse J. Arnold III/spouse 1417 Stafford Road Darlington, MD 21034 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☑ Donation 5 ☐ Other (Specify) Sign of Francisco Line Ronald S 22. Name and Address of Facility.
State Anatomy Board 655 W. Baltimore Street Director MD 21201 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition GASTRIC CANCER Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month 1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? è 2 No 3 Probably 4 Unknown 1 Yes Completed should peen . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed

Records, P.O. Box 68760 DAWN ARNOLD Hospital or Attending Physician: The Division of Vital

6:35

2011

1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\blacksquare$  Other (Specify) **HOSPICE** 1 🗌 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. **Certifying Nurse Practioner:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title License number 29d. Date signed (Month, Day, Year)

rson who completed cause of death (Item 23a) (Type, Print) 30. Name and ac

2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

32. Regist

State Registrar

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Certificate:

Medical

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n 24 hours after death.

e Funeral Director: A pleted filled in by the fu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6:40 p. Bell June 5 Algard Joseph Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Sykesville Copper Ridge If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 - F Months (Month, Day Year) 07/21/1920 Maryland Director 90 Yrs. 219-18-4481 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Carroll 1 Tes 2 No MD New Windsor 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2976 Union Square 21776 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 XMarried δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 Self-employed Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည Stewart Dallas Bell Eva Olevich permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia W. Bell / Wife 2976 Union Square, New Windsor, Maryland 21776 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) oudon Park Cemetery 6/10/2011 Baltimore, Maryland Hubbard Funeral Home, Inc. 21 Sign ture of Funeral Service Licensee 22. Name and Address of Facility 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last nding physician are as the burial-Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atten in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death P.O. signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 24 hours after death.

Funeral Director: After this certificate 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medica Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ည ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 25059943 6,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AL SUPE 307 275 rear) . Registrar's Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WAYNE BRUCE 1) 10244 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GEN BURNIE MD ALTIMORE FRINE ARUNDEZ WASHINGTON MEDION CNTD 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** M 2 D F Month Bay, **Director** 28a-f shov the Medical Examiner must be notified at 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No Arunde DIN 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a ONLLK U.S 12. Was Decedent Ever in U.S. Armed Forces 1
1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 9 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Black "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) School Todian Be 17. Father's Name (First, Middle 18. Mother's Name (First Middle, Maiden Sumame) Sruce permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. amos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Williams COUSIN 025 Mill Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State 6-18-2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens e 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CARDIM Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner VNFNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit UNRNOWN To the Hospital or Attending Physician: The law requires that the death certificate be executed 1SCHEDNIC CARDIO MYOPATHY and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death be detached g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THROMBOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No MYPERLIPIDEMIA within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 No Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 [ only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D 4055464 MO 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GALEN OHNMACHT 305 HOSPITAL DRIVE, GLEN BURNIE, MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUN 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienez for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Drown June 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Village Care arles timore Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)
June 15 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 M 219-30-844 Months Country) 76 Yrs. Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director notified MI 28a-f 1 Nes 2 No 7 M 520 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? pe 23a must 2120 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Examiner Armed Forces?

1 Yes 2 No ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural" 3 Widowed 4 Divorced Specify: Blac Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical ! 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ၉ naries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Department of Health Important: If item 27 any injury or other to once. ton 21205 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remov 201 4 Donation 5 Other (Specify) National eral Service Licen 22. Name and Address of Facility HOUL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Day Year 1 Yes 2 No Pregnant at time of death the detached g Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' After this certificate ! 2 🗷 No Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural n 24 hours after deaun.

ne Funeral Director. Aft 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRE ETIMDER 5 ANDITU 1940W. BALTIMORE JT. BALTI MORE. MD MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 9 2011 Barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 2011 Physician/ MARIE ELLEN BELL JUNE 8 1:19 A M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 - M 2 - F Months Hours Min 9 - 1,7 ay, 1 9 25 214-20-6178 85Yrs. MARYLAND **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD HARFORD BEL CAMP 1 🗆 Yes 💥 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4220 BAYLISS COURT 21017 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married ρ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: WHITE 3

✓ Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME should be filed with h and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GEORGE HEFFERNAN CATHERINE UNKNOWN traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau JUDY HICKS/DAUGHTER 12 MEADOW SPRING DRIVE BEL AIR, 21015 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, HOLLY HILL MEMORIAL 4 Donation 5 Other (Specify) 6-10-11 MIDDLE RIVER, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 21. Signature of Tenand Se 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 🐔 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ u MON aru disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. In the Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami g physician and as the burial-trans Due to (or as a consequence of): Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2 No Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 🗷 No Other: 1 Kopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Natural
Accident 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of D0053568 500 upper Chesapeake Driv cause of death (Item 23a) (Type, Print) I HOMPSON MD Maryland 21014 Bel 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

071717008W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day John J. Bishop, Jr. June 6 2011 12:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6671 Loch Hill Road Baltimore Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8 Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1X M 2 🗆 F Dec 6. 214**-**22**-**7318 83 **1927** Maryland Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6671 Loch Hill Road 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' should be filed within 72 hours after don and Mental Hygiene. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Marvland Court of Elementary/Seconday (0-12) 12 College (1-4 or 5+) 5+ Special Appeals Judge Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Joseph Bishop, Sr. Mary Lillian Freshline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Karen Frew 13510 Alliston Drive; Baldwin, MD 21013 daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 D Ther (Specify) Julaney Valley Mem Gardens | 6/11/2011 Timonium, MD 21. Signature of Funeral Service Licen 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one c ay sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ veeks Medical resulting in death) Examiner Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last as the burial physician by Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one examiner? Other: 2 VINO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 266. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) Atlending 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Newland Rd MD SCHWARTZ 3572 32. Registrar's Sgnature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 AM 1040 PZMARMAG RHIMOMO KWAC BOAFC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER 085 SPRING HOSPITAI MONTGOMERY CR If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Country) 1 M 2 □ F (Month, Day, Director 0 Usual Residence of Decedent r 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No CHITHERSBURG MONTGOMER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral 2087 HRISTOPHER items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates Specify. "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working d Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) INFANT INFANT W traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ပ ROAFO ISHMAEL CAWN SA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 CROSS HOSPITA GLEN RD HOLY FOREST C1805-0745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If its any injury or oth 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State 4 Donation 5 V Other (Specify) in state Sin atur of Funeral Sonice Licensee Rom d S Wa 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph/sician/ ANEN CEPHIAI disease or condition resulting in death) NYS Medical Due to (or as a consequence of): Examiner LIP hrs LEEL Sequentially list conditions. Directo for as a consequence of cause. Enter Underlying Cause (Disease or iinjury transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 Pregnant a Month Pregnant at time of death 2 🗌 No the 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗖 No Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature d title of certifier 29d. Date signed (Month, Day, Year) D 24121

State Registrar 1500 POREST GLEN RA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAWN

31. Date filed (Month,

MOPIAW

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of	Maryland		artmen rtificate			and M	ental Hyg	jiene 1		18280	
Dhua	inian	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death	
Phys /Me	dical	George Brown								May 7,		. of Dooth	2:30 PM <sup>M</sup>	
Exan	niner	4a. Fecility Name (If not institution		oer)				Location o			4c. County	or Death		
		Future Care H		Age (In yrs. la	ast birthday)	If Under	1 Year	imore	24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign	
Funer Directo		219-32-4528	1 <b>∑</b> M 2□F	74	Yrs.	Months	Days	Hours	Min.	Feb 24,	1937	Mar	yland	
D		Usual Residence of Decedent		10- Cib	r, Town or Lo								10d. Inside City Limits	
anylar show	5	10a. State 10b. County		Toc. City		Ltimo	~^						1√2 Yes 2 □ No	
the M	ecto	MD 10e, Street and Number		l	Da.	10f. Zip			_		10g. Citizen of	What Cou	untry?	
3a or	Funeral Director	123 W. 29th St	reet #5L				2	21218			Ţ	ISA		
death	nera	11. Marital Status	12. Was Deced		S. 13.	Was Deced	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra Bla	ce - Amer	ican Indian, etc.	
or its	E P	1 ☐ Never Married 2 ☐ Mar	nied 1 ☐ Yes 2	₩No		1 ☐ Yes		Specify:				y: bla		
17213-UU36 within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Experiment by motified at	d by	3 ☐ Widowed 4 🖺 Divorced	Year or Date  's Education	es:	16a Dece	dent's Usua	al Occupa	ation			16b, Kind of E	Business/l	ndustry	
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y with	E	Elementary/Secondary (0-12)	College (1-4	(or 5+)	st	evedo	ore				bo	ating	g	
a file	Be	17. Father's Name (First, Middle,						18. Mothe		e <i>(First, Middl</i> e, s <b>ie</b> Brov		ne)		
YIAN Ould b Ment Ment Ment Ment Ment Ment Ment Ment	ဥ	John Edward Fo			T II a a a a a a a a a a a a a a a a a a		1-					Ctata 7	in Code)	
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Te, 1 enc Healt tem 2		20a. Method of Disposition		20b. P	lace of Dispo	osition (Nar	ne of	and I	(	Date	20c. Location	- City or T	Town, State	
Pages ent of nt: if i		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (		late	emetery, cre	matory or c	Mier piac	9)						
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Nadical Examinat must be publiced.	DUCE	21. Signat Ire of Funeral Service	Lio nego	irector		tate and altim		-	66ard 2120	655 W.	Baltin	nore	Street	
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Physicia	an	Immediate Cause (Final disease or condition	-	r as a consequ	molo	1 A	ecid	lent					Onset and Death	
/Medic Examin		resulting in death)	Due to (o	r as a consequ	uence of):									
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sa a	Physician/Med	IF FEMALE:	00 1/1	500000000000								22d Date of delivery		
BOX leath cert attendin I for use	ian/	23b. Was decedent pregnant in the past 12 months?	23b. Was decedent pregnant  23c. If yes, outcome or pregnancy									23d. Date of delivery  Month Day		
P.O. thet the de ad by the detached	Vsic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov		eath 5	0(1101 (3)	Journ 1 -							
s thet had by a deta	yd P		ions contributing to dea	ath but not res	ulting in the	underlying (	cause giv	en in Part	1.	23e. Did t	obacco use co	ntribute to	the cause of death?	
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on of Vita ding Physicien: h. After this certific funeral director,	2	/	Hospital: 1 □ In 28a. Date of	patient 2	ER/Outpatie		UA	41.1719	ursing Ho	ome 5 Resi			cify)	
After June	tion	1 Natural 5 Pend		n, Day Year)	Injury	м	28c. Injur Wor 1 🗆	rk? Yes 2.⊑	]No	2001 2000 100	.,			
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Div s after at Dire	Cert	4 Homicide	buildin	g, etc. (Specif	<b>Y)</b>	G1224				City of 10	wii, State)			
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To the within To the	M	29b. Signature and title of certif	er / ·			29	c. Licens	e number			29d. Date sign	ned (Mont	th, Day, Year)	
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		30. Name and address of perso	n who completed cause	of death (Item	n 23a) (T	Print)	1-	0	0	BIH	1	110 3	th, Day, Year)	
c   m	Charle	31. Date filed (Month, Day, Yea	The Hap Ri	egistrar's Sign	ture	15(0)	Low	m	11	ilare	mage	, ,	1-1)	
Reg	State istrar	IIIN O	2011 Jeny	in B	ga	Lead								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 10:40 PM Charles Elmer Cluster Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** n/a Baltimore Union Memorial Hospital 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Pay, Year, 5/26/1937 Hours 1 🕅 M 2 🗆 F Months Maryland Director 219-32-9778 74 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No Glen Burnie Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe Funeral 21061 USA 122 Janelin Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11, Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) City Government Police Officer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) of Health and Mental H if item 27 is marked of r other traumatic ever ၉ Lillian G. Trust pe James T. Cluster permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles T. Cluster / Son 122 Kanelin Drive, Glen Burnie, Maryland 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/7/2011 Baltimore, Maryland 22. Name and Address of Facility Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final BRONBRY Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to for as a cons if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as signed by the attending I be detached for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown P.O. I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 X Yes 1 Mnpatient 2 ER/Outpatient 3 DOA 욘 this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: M Natural 5 Pending Investigation 6 Could not be ☐ Accider☐ Suicide Accident within 24 hours after death

To the Funeral Director:
completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifi 00020111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Union 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June Day Lee Caputo 2011 8 5:00 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City. Town, or Location of Death **Examiner** Reisterstown 3410 Buttonwood Court Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 □ M 2 🙀 F Oct 15 Days 216-20-1996 85 1925 MD **Director** Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10d. Inside City Limits at 10c. City, Town or Location Director must be notified Reisterstown 1 ☐ Yes 2 ☐XNo Baltimore 10g. Citizen of What Country? 6 10e. Street and Number 10f. Zip Code Funeral 23a USA 21136 3410 Buttonwood Court Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: white 3 Divorced 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Hercules Rider Alice W. Mackennon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3410 Buttonwood Ct., Reisterstown, MD 21136 19a. Informant's Name/Relationship (Type, Print) Mr. Daniel Caputo (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Xremation 3 Removal from State All County Cremation 6-9-11 4 Donation 5 Other (Specify) Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel (Hay March 1) P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b, Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) avio 55 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DI Medical 4a. Facility Name (if not institution, give street and number) or Location of Death County of Death **Examiner** Henburnie ware | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. (Month, Day, Oct 20, ecurity Number 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ 1941 Maryland Director 235-64-2618 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Gambrills Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21054 2256 Time Drive 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 ☑ No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates Maryland 21215-0 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) US government electrical engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Opal Atkinson Eugene Flemming Cobbs Sr 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 2256 Time Drive Gambrills, MD 21054 Janet Cobbs/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signat of Funeral Sep Le 22 Name and Address of Facility Board 655 W. Baltimore Street Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ respiratory acute disease or condition Medical resulting in death) Due to (or as a c no equence of) **Examiner** neumonia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? carcinoma 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2X No မ 1 patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗆 No 1 🗌 Yes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature 2 of person who completed cause of death (Item 23a) (Type, Print) (Month, Day, 32. Registrar's S State 9 Registrar

11-03929	1-03929
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

onnie Lee Cleave	1-	For State	State	e of Marylar	nd / Depa	rtment of tificate of	Health Death	and	Menta	al Hyg		Reg. No.	20	A STATE OF THE PERSON NAMED IN COLUMN 1	18281
Physician		. Decedent's Name	(First, Middle,L	ast)		<u> </u>					Date of De	ath Day	Yea		3. Time of Death
Medical Examine	T			Cleaver						_	May 26,	2011	c. County c	of Death	0800 hrs
	4	a. Facility Name (if Frederick Me			nber)	4	b. City, To Frederi		ocation of	Deall			Frederic		
Funeral	5	. Social Security Nu			7. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24Hrs.				LEocoion	place (State or
Director		213-24-		X <sub>M</sub> <sub>2</sub> <sub>F</sub>	4(	) Yrs.	Months	Days	Hours	Min.	06/2	25/1	1970	Foreign Cou	ntry) MD
	ţ	Jsual Residence of													10d. Inside City Limits
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th the Maryland 23a nr 28a-f sho notified at once	Director	31C Fie		t Blvd	#203			701				US	SA		
within 72 hours after death with the Maryland jene.  rer than "natural", or items 23a nr 28a-f sh Medical Examiner must be notified at once		1. Marital Status		12. Was Dece	edent Ever in U	.S. 13. Wa	s Deceden	of Hisp	anic Origii	n? (Spe	cify Yes or I	No-	14. Race White		can Indian, Black,
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after o	<u> </u>	3 Widowed		ed If Yes, Give Year or Dates:		1 16a. Deceden	Yes 2			ind of wo	urk done	16h	Specify: Kind of Bu	siness/lr	ndustry
136 hin 72 hours a e. than "natural edical Examin		15. Decedent's Ed		only highest grade College (1-		during m	ost of work	ing life. [	DO NOT u	ise retire	d)	100.	74110 01 04		,
36 hin 72 e. than '	Die	12	idaly (0-12)	oonege (	, ,	Prin	ter						Print		9
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D 21215- should be filed and Mental Hyg 7 is marked oth	2 [	19a Informant's Na Dawn Nic	me/Relationship ole Cl	(Type, Print) .eaver V	Vife	31C	Fiel	dpo	int	Blv	d #2	03	Fred	eric	ck MD
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Baltimore permit. Pages 1 a Department of He Impartant: If it injury or other t		4 Donation 5 21. Signature of Fur	Other Special Service Lie			22. N	lame and A	Address	of Facility	Sim	plic	ity	Cre	m &	Fun Serv
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Box 68760, e death certificate be the attending physic of for use as the burded for use	Sici	1 Yes 2		1	ant at time of d	leath 5 0	ther (Spec	ify)							
the de	Physician/Me	Part II. Other signi				resulting in the	underlying	cause g	iven in Pa	rt I.	23e. Di	d tobacc	co use cont	ribute to	the cause of death?
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e law te has ge 2 sl	Completed										1 <b>✓</b> Y€	erformed es 2		death? 1 <b>✔</b> Ye	es 2 No
A R	S B	25. Was case refer	red to medical						of Death						
Vita hysicia this ce	9 2	examiner? 1 <b>✔</b> Yes	2 No		Inpatient 2	ER/Outpatien					g Home 5			Othe	f.
Ing P		27. Manner of Dear			n, Day,Year)	28b. Time of			ryatWork ∕es 2∑X		Unkno		ingury occur		
SiOr Attend death death ector:	ä	2 Accident	Invest	gation 28e Plac	-26-11 ce of Injury - At	fd 6:0 home, farm, stre					28f. Locatio	n (Stree	et and Num	ber or Ru	ural Route Number, City
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 4 Homicide	6 X Could determ	not be	In a ve					- 1	or Tow Frede	n, State cick	,Md .	amil ———	ton Ave.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one)		rsician: To the be	st of my knowle	edge, death occu	urred at the	time, da	ate and pla	ace, and curred a	due to the d	ause(s) ate and	and mann place, and	er as stat due to th	ted he cause(s)
To the comp	Medical	29b. Signature ang		and manners	stated.				e number						onth, Day, Year)
	7	All	L.B.	assell.	MD			O.C.	M.E.			M	lay 27, 2	:011	
		30. Name and add					N/ Raltin	nore S	Street P	altimo	re, MD 2	1223			
		Melissa Bra		Assistant Me	egistrar's Signa		v. Dailli		rii eet, D		, IVIO Z				
St Regist	ate rar	31. Date filed (Mor	0 9 201	Ann	a d	back	1								
DHMH 17 Rev 1/20	001		OCME		-	ORIGIN	AL								

Gwendolyn Demby

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 5, 2011 0336 hrs **Medical Examiner** Demby Gwendolyn 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Ft.Washington North Route 210 @ South of Wilson Brige Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours CountryDC Nov.10,1957 225-90-4965 Director 53 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 1 X Yes 2 No Manassas Park Va. Prince William 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 20111 9210 Matthew Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 12 Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? 1 Never Married 2 X Married Black 2 X No 1 Yes 1 Yes 2 X No specify: 4 Divorced If Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Design Desk Top Publisher timore, MD 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Sylvia Robinson Be Roy Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9210 Matthew Drive Manassas Park, Va. 20111 Timothy G.Demby-Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) ી **દ** Pages 1 1 XBurial 2 Cremation 3 Removal from State Centreville, Va. 6-11-11 Robinson Memorial 4 Donation 5 Other Specify: 22. Name and Address of Facility Chinn Funeral Service 21. Signature of Funeral Service License 2605 S.Shirlington Rd.Arlington, Va. 22206 overt 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Exami Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - trans ician/Medical UNPENDED AMENDED . Box 68760, he death certificate be ex 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown After this certificate has been signed by the att funeral director, page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Š Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed death? Yes 2 No 1 🗸 Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital 8 examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Jun 5, 2011 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Ejected Passender from vehicle Certification 0315 hrs 1 Natural 1 Yes 2 ✔ No in 24 hours after death.

le Funeral Director: A letely filled in by the fi Pending 2 🗹 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) North Route 210 @ South of Wilson Brige , Ft.Washingt determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the To the I and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number June 5, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Jack Titus MD. 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			_ For	State of Ma		Depa	artment of H	lealth a	and Me			18286	
			1 - State Registrar			Cer	tificate of	Death			. No. U		
	Physicia	an	Decedent's Name (First, Middle, Last)	_						Date of Death Month	Day Year	3. Time of Death	
	/Medic		Beatrice A. Dai				# 63 T	.1		May 12,	2011 4c. County of Deat	10:35 PM	
	Examin	er	4a. Facility Name (If not institution, give st				4b. City, Town, o		or Death		Frederi		
			Golden Living C  5. Social Security Number 6. Sex		e (In yrs. last bii	rthday)	If Under 1 Year	If Under		. Date of Birth		nplace (State or Foreign untry)	
	Funeral Director			M 2∏F	79	Yrs.	Months Days	Hours	Min. S	(Month, Day, Yept 14,	1931 Penr	untry) Isylvania	
	p ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	vn or Lo	eation					10d. Inside City Limits	
	faryla shov	ō	MD Frederick				erick					1 ☐ Yes 2 ☐ No	
	the N	Director	10e, Street and Number		I.	Leac	10f. Zip Code			100	10g. Citizen of What Country?		
	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "naturelt, or Items 23s or 28s-f show after than "naturelt, or Items 23s or 28s-f show ent, the Madical Examination must be notified at		30 North Place					2170	)1		USA		
	death	Funeral	11. Marital Status 1	2. Was Decedent 8 Armed Forces?	Ever in U.S.	13. \	Was Decedent of H	lispanic Or	igin? (Specif	y Yes or No-	14. Race - Ame Black, Whit		
٥	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 🕅 N If Yes, Give	lo		1 ☐ Yes 2 ☑ No			,	Specify: wh		
ğ	hours urel',	d by	3 💢 Widowed 4 □ Divorced	Year or Dates:	1. 100		dantin Herral Casse			1 14	6b, Kind of Business/	20.00	
င်	a within 72 ho pene. r than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos d)	st of working	,	DD, Killid of Dusiness	andustry	
7.1	with iene. than	шо	Elementary/Secondary (0-12)	College (1-4or 5	+)	hou	ısekeeper				cleanir	ıg	
0	illed Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (/	First, Middle, Ma	aiden Sumame)		
<u>a</u>	should be filed within ind Mental Hygiene. s marked other than " umatic event, the Mar	To B	John Andrew Barco								beth Snyde		
Maryland 21215-0036	0 0 0	Ĺ	19a. Informant's Name/Relationship (Typ								City or Town, State, 2	Zip Code)	
	other tre		Carl Coleman/step	son			Pontiac D	rive	LIWOO		Town State		
More			20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  1 ☑ Donation 5 ☐ Other (Specify)	emoval from State	cemete	ary, crer	osition (Name of matory or other pla	ce)	Dat		0c. Location - City or	Town, State	
	permit. Pages Department of Important: If It any injury or of		21. Signature Ponald	and fre	ctor			-	Soard 21201	655 W.	Baltimore	Street	
			23a. Part1 Enter the disease, or complic	cations that caused	the death. Do		altimore, ter the mode of dy			respiratory arres	st,	Approximate	
l,			shock or heart failure. List only on Immediate Cause (Final	e cause on each lu	ne.		reast (					Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as	a consequence	-	7051	unc	tv				
	Examiner												
	7 5	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):							
	and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to fee a		of).							
,60	eath certificate be executed attending physician and for use as the burial-transit	cai E)		Due to (or as	a consequence	9 (11).							
687	physicate sthe		d		_						,	1	
	certif nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant			23d. Date of de	d. Date of delivery						
Box	death certifical e attending phy id for use as th	Completed by Physician/Medi	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			∃Ectopic pregnand ∃ Other (specify) _	У			Month	Day Year	
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	The law requires that the de ate has been signed by the a page 2 should be detached f	by F	Part II. Other significant conditions con	,	13	1.		_				o the cause of death?	
ord	w require been sig should b	ted	Chance obs	tructive	e 14	100	onary	DISY	cone	1 🗆 Ye:			
Vital Records,	elawi hasbu	npie								24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
<u> </u>	cate cate	S									No 1 □ Ye	3 2 □ No	
	Physician: The la rthis certificate has rai director, page 2	Be	25. Was case referred to medical examiner?	ospital:	- 7		0:	hor	_	Check only one			
o	Phys r this rai di	1: To	1 Yes 3 No	28a. Date of Inju	ent 2 ☐ ER/0 iry 28b.	Time o	of 28c. Inju	iry at	-		nce 6 Other (Spe w injury occurred	эспу)	
O	th. : Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	Wo	ork? ]Yes 2[	□No				
Division of	or Attanding Phatter death. Diractor; After the	Certification:	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home, to. (Specify)	farm, st	reet, factory, office		28	Sf. Location (Str. City or Town	eet and Number or F	tural Route Number,	
	s after et Dira	Cert	4   Homicide	Daliding, et	c. (Spacity)					0.1, 0.70			
	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funerel Diractor: After this certifica	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best ner: On the basis o and manner st	f examination a	ge, deat Ind/or in	th occurred at the to restigation, in my	ime, date a opinion, de	and place, ar eath occurred	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen	se number		29	d. Date signed (Mor	th, Day, Year)	
			100-	Nt			D60	417	7	6	-1-20	)) ·	
			30. Name and address of person who co				, Print)						
				5 c Tho	mare,	TU	veca I	r,	trec	FNICK	MD 21	702_	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 0 9 2011	32. Registr	ar's Signature	par	moon I						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Martha Hollifield Dorman 2011 2:15 A June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson Social Security Number 9. Birthplace (State or Foreign Country) Georgia 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 - M 2 X F Days Hours Min. 6. 191 213-46-0923 Yrs **Director** 99 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland N/ABaltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1305 Roundhill Road U.S.Apermit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other transitions. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Clinton Hollifield Annie Mae Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Anne Dorman Clark (daughter) 1305 Roundhill Road Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Saters Baptist Church Cem ! 6-11-11 Lutherville, Maryland <sup>22</sup> Name and Address of Facility Mitchell-Wiedefeld Funeral Home 6500 York Road Baltimore, Mary 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hointeilmal Ph\_sician/ disease or condition 12 Medical resulting in death) Du o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the all be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 X No 1 Yes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death. To the Funeral Director: After this certificate has autopsy page 2 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 D Other (Specify) Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Dealt 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and little 29d. Date signed (Month, Day, Year, eil

State Registrar

ANNES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 18288 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 3:49 AM BABUQUEL Ellis 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Balkmon Com RESECONDE (MA) Square 8. Date of Birth (Month, Day, Year) May 27, 2011 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 5. Social Security Number Min 32 Mary land 1 - M 2 X Months infant Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 X No Dundalk Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 4045 St. Augustine Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. 1 X Never Married 2 Married white 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kayla Ellis Dustin C. Wiland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Franklin Square Hospital 900 Franklin Square Drive Rosedale, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state State and Add to migaci Board 655 W. Baltimore Street Sign pur of hyperal Serve bicense, Director 21201 Baltimore, MD Approximate

Ph\_sician/ Medical Examiner

Physician/

Medical

**Examiner** 

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

"natural", or items

other traumatic event, the Medical

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me

Director

Funeral

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Completed

Be

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should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit death certificate be executed attending physician for use as the burial #230-d Division of Vital Records, P.O. Box 68760 n signed by the a Ild be detached f To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I

	shock, or heart failure. List only of	one cause on each line.	1 - 16/2 11.			Interval Between Onset and Death
	Immediate Cause (Final disease or condition	a. Due to (or as a consequence of):	at 21°1+ M6			Officer and Boats
	resulting in death)	a. Due to (or as a consequence of):				
Ш		PRETERM LABOR				
miner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b.  Due to (or as a consequence or).				
l Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):				
edica		d,				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 M Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3  Ector 4  Pregnant at time of death 5  Other	pic pregnancy r (specify)		23d. Date of delivers	Day Year
d by Ph	Part II. Other significant conditions of	contributing to death but not resulting in the underlyi	ing cause given in Part I.		use contribute to th	e cause of death?
omplete				24a. Was an autopsy performed?	prior to con death?	osy findings available mpletion of cause of
Be	25. Was case referred to medical		26. Place of Death (Check of	only one)		
10 B	examiner? 1 Yes 2 No	Hospital: 1 ★ npatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Hom	ne 5 Residence	6 Other (Specify	)
icate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1 ☐ Yes 2 No	8d. Describe how inj		
Certif	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ctory, office 2	8f. Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
Medical Certificate:	(Check 2 Modical Evan	ysician: To the best of my knowledge, death occure niner: On the basis of examination and/or investigation arse Practioner: To the best of my knowledge, death of	in my opinion, death occurred at t	he time, date and pla	ce, and due to the cal	use(s) and manner stateu.
2	29b. Signature and title of certifier	. 0	29c. License number		Date signed (Month,	
	Danist 1	And	RESOCOO		5/27/11	

roman Dr. Rosedale MO

DHMH 17 Rev 7/2009

State Registrar a NO Trankly

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 0215 Seibert H. Everetts Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Dec 11 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 79 **Director** 177-24-9905 Dec Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7 E. Washington Street #405 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 X Yes 2 □ No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Ō food industry cook injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Everetts/son P.O. Box 158 Reedsville, PA 17084 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Othe (Specify) Sign itur of Funeral Service Stare and Address of Facility oard 655 W. Baltimore Street Director Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between nse a e to ) Y( bon n) Y Q Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? detached for Month Day Year Pregnant at time of death 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? þ page 2 should be Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No **Division of Vital** funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5  $\square$  Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and

State Registrar 30. Name and ad

31. Date filed

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>011</u> Month **Physician** 5, 5:35 A<sup>M</sup> SHIRLEY J. FEIT JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MANOR CARE RUXTON TOWSON If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1 M 2 F 80 Yrs 9-24-1930 MARYLAND 212-28-3410 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 XNo MD PERRY HALL Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21128 8716 SILVER HALL ROAD Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates: 2 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical 72 Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JOHNSON** CLIFTON MARGARET ELLIOT ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21128 CHARLEEN MAY/DAUGHTER 8716 SILVER HALL RD PERRY HALL, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEM. 6-9-2011 REISTERSTOWN, 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fundal Pervice Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failnre **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner westens in Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Examiner as the burial-transit Demention Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jayunt

30. Name and address from who completed cause of death (Item 23a) (Type, Print)

M.D

3 Registrar's Signature

Hi Mara

JUN 0 9 2011

SYLAW

DHMH 17 Rev 1/2001

7505

29c. License number

252749

OSIEV Drive

29d. Date signed (Month, Day, Year)

0G-06-L1

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ By 6:30 PM June 2011 Donna Lee Fleck Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours January 11 1 □ M 2 🗓 F 69 220-42-9882 Maryland .1942**Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director Timonium Maryland Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 227 Chantrey Rd. 21093 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Fyamina once. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: white Completed 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) state government administrative assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Lilly Anna June Peters Paul Herbert Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Redwood City, CA 94062 10 Canepa Ct. Aaron Whitt/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 
Burial 2 
Cremation 3 
Removal from State Green Mount Crematory June 9,2011 4 Donation 5 Other (Specify) Baltimore, Maryland John O. Mitchell IV, Funeral Services of Dulaney Valley, Timonium MD 21093 P.A. Signature of Funeral Service Licenses Witch E. Padonia Rd. Timonium. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concel Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or se a consequence di) Cause (Disease or iinjury that initiated events physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s autopsy perform 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 2 No 6 X Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 ☐ Pending \_\_Investigation work? 1 ☐ Yes 2 ☐ No I Director: A Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical \*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HALIB 31. Date filed (Month, Day, State JUN 0 9 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 30 2011 Physician/ 12:20 P M Green May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Days Nov. 13, 1923 1 🗌 M 2 🔀 F 87 Louisiana **Director** 434-32-107.0 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 🗌 Yes 2 🔀 No Assumption Belle Rose LA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 70341 144 Klotzville Lane 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married Yes ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. **Black** If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alphonsine Landix Larry Larkins 195 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7/15 Georgian Drive
Upper Mariboro, Maryland 20772 19a. Informant's Name/Relationship (Type, Print) Laverne Green - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Augustine
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Barial 2 Cremation 3 Removal from State 6-10-2011 Klotzville, LA Donation 5 Other (Specify) 22. Name and Address of Facility Williams & Southhall Funeral Home Sig ature of Puneral Service License 70390 5414 Highway 1, Napoleoville, LA Þ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final E Ph\_sician/ Medical resulting in death) Due to (mas a consequence of) Examiner 130WEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and -tran that initiated events Due to (or as a consequence of resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown been signed by the s should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 1 🗌 Yes 2 🗶 No Yes 2 🗓 this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: ၉ 1 Tes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending 1 Yes 2 No s after death.

I Director: A
ed in by the fu Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours at To the Funeral D completed filled in Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. signed (Month, Day, Year) nd title of certifie 29d. Date 29b. Signature 3885 31 2011 and address of person who completed cause of death (Item 23a) (Type, Print) SURRAT 501 32. Registrar's S State Registrar

DHMH 17 Rev 7/2009

Please Type or Printin Black Indelible Ink: Engure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ June Day 201<sup>Y</sup>1<sup>a</sup> Robert Louis Gaither 11:20a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5029 Green Bridge Road Dayton Howard Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**火** M 2 □ F Days Hours Months 214-16-8001 90 Director June T921 MD Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Dayton 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5029 Green Bridge Road 21036 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No WWII If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: black Completed 3 Divorced 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. engineering the operating engineer permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumation once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Lloyd Gaither Rose Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alda Gaither (spouse) 5029 Green Bridge Rd., Dayton, MD 21036 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Crest Lawn Memorial 6-11-11 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daugh Hought 2 Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on a colline. shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural 2 Accide iniury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 1 🜋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatu 29d. Date signed (Month. Dav. Year) 411 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00. Lement Knight M.D. 10710 Charter Drive Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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cal ner	4a. Facility Name (if not institution	on, give street and number		<u>dham</u>	4b. City, Town, o	r Location of Death	June		ZUII  c. County of Death	12:00 P
	4411 Meadowcl					rm		В	altimore	
	5. Social Security Number 216-77-6898  Usual Residence of Decedent	6. Sex 1 \( \text{M} \) 1 \( \text{M} \) F	95	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 10/13/		g. Birth	nplace (State or Foreign etry) 1 a
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Director	Maryland Balt	imore	Gle	n Arm						1 🗌 Yes 2 💢 N
a D	10e. Street and Number				10f. Zip Code				itizen of What Cou	untry?
Funeral	4411 Meadowc 7	liff Road  12. Was Deceder	t Ever in U.S	S. 13 V	21057 Was Decedent of H	lispanic Origin? (Sr	necify Yes or No-	_	dia 14. Race - Ameri	icon Indian
by F	1 Never Married 2 Ma	arried Armed Forces	?	1	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		Black, White	
ted	3 🗓 Widowed 4 □ Divorce				1 ☐ Yes 2 💢 No	Specify:			Specify: Asi	an Indian
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Be	17. Father's Name (First, Middle,			Lieuci	101	18. Mother's Nar	me (First, Middle,			
မ	Augustine Gar	ndham				Kondamm			,	
	19a. Informant's Name/Relation			19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City o	r Town, State, Zip	Code)
	Samson Vimala	amanda/ Son		4411	Meadowc	liff Roa	d, Glen	Arm	MD 2105	7
	20a. Method of Disposition 1 → Burial 2 □ Cremation	n 3 🗆 Removal from Sta			osition (Name of matory or other plac		Date	l l	ocation - City or T	
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	21. Signature of Funeral Service	e Licensee/		22	2. Name and Addre 105	Roffowson	Funeral	Hon	ne, Inc.	1
	23a. Part 1. Enter the disease, of	or complications that caus	ed the deat	h. Do not ente	er the made of dvin	n such as cardiac	or respiratory ar	rest	10. 2120-	Approximate
	shock, or heart failure. List Immediate Cause (Final	t only one cause on each I	ine.							Interval Between Onset and Death
	disease or condition resulting in death)		s a consequ		INFAR	CITON				5 YEAR
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iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	b. ————————————————————————————————————	s a consequ							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c, 22 per fn g916 6-15-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Dededent's Name (First, Middle, Last) 2. Date of Death 8 Physician/ JUNE 201 reen Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Country) SC Funeral Days Months Hours O S - 2 Pay, Year 1**X** M 2 □ F 69 220-38-5162 Director Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🖁 Yes 2 🗆 No Baltimore MD NA 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21223 Fayette Street 2136 W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No 1 Never Married 2 ☐ Married Completed by 1 Yes 2 No Specify Specify: American Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", any injury or other traumatic answers. 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) H & M Bakery Baker NA 10th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BREEN WILLI Lucille Conyers Green Ephriam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2136 W. Fayette Street Baltimore,MD 21223 Juanita Williams-Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of Mccemetery, comatory of other place)
Mt. Caramel Cemetery Gatonsville, MD 1 x Burial 2 Toremation 3 Removal from State 06-14-11 Baltimore Funeral Home P 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21217 Wylie 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Street 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onsut and Death Immediate Cause (Final ensis Physician day disease or condition Medical resulting in death) Due ( (or as a consequence of): Examiner Tou day Va Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 \ No Ves g 🗌 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hepestocella 1 🗌 Yes 2/No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed? 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Other: 2 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: Natural injury 5  $\square$  Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29c. License number 29b. Signatu eted cause of death (Item 23a) (Type, Print) Glen Burnie, OY 31. Date filed (Month, Day, Year) State JUN 0 9 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month June 2011 Marjorie Reuwer Gunther :20 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Harford 114 Driftwood Court Joppa If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 □ M 2X F Months Hours July 30 215-22-3131 83 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 ☐ Yes 2X No Joppa Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Driftwood Court 21085 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Milton John Reuwer Pauline Duerr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Gunther (daughter) 114 Driftwood Court Joppa. Marvland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State Oulaney Valley Mem. Grdns. 4 Donation 5 Other (Specify) 6-9-11 Timonium, Maryland 22 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Signature of Funeral Service Licensee 23a. Part 1. E wir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Perioheral vuscolar disease Sequentially list conditions, if any, wating the immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Diabetes that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Day 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Rheumatoid Arthrit 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed?
Yes 2 X No Hypertenson 1 Yes 2 No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Falls

# 225

MD

MU

10753

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 210 CIN nda Medical 4c. County of Death Facility Name (if not institution, give street and number) Town, or Location of Death 4b. Citv. Examiner of NW Baltimore Hospice) Kandallsaur ttospita 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign lf Under **Funeral** 1 □ M 2 🔀 F 58 Months Hours Min. Country) Director 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director Baltimone MD 1 Yes 2 No 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? Tucker Lane #Blo 21207 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Officer Hand Man the orrections State ut years and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental h Important: If item 27 is marked of any injury or other traumatic annumatic annumatic annumatic annumatic annumatic annumatic annumatic annumatic annum ျ Odessa Washington Rikard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Brooks Baltimone MD Tucker Lane #Ble HUSBAR William 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Owings Mills, MD tovest 4 ☐ Donation 5 ☐ Other (Specify) Tarrison Greene Puneral Services re of Funeral Service Licensee 22. Name and Address of Facility Vaug odallstown MD 21132 Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) neumon Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and Exami that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): -burialattending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death been signed by the should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No this certificate 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) nos Hospital 1 🗌 Yes Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this completed filled in by the funeral dil Nursing Home 5 Residence 6 Other (Sp 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work' 1 Tyes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title sm BUB State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 2<u>011</u> Physician/ 20:40P M Earl Huber Raymond June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore City The Johns Hopkins Hospital Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 1 M 2 🗆 208-26-4377 Director 77 1-9-1933 PA Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Carroll Westminster 1 Yes 2 XNo MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 237 Bezold Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 😾 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Breidenbach Albert C. Huber and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Gladys M. Huber-wife 237 Bezold Ave., Westminster, MD 21157 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evergreen Memorial 6-11-11 Finksburg, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Fletcher Funeral Home Honas 21157 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Metastatic Neuroendocrine Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed' death? 2 No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital Other: မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 June 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St, Baltimore, MD, 21287 PINDE

DHMH 17 Rev 7/2009

State

Registrar

ed (Month, Day,

0 9 2011

**ORIGINAL** 

32. Registrar's Signature

Patient known as Jacqueline Faye Hartman

		_	For State		State of M	arylan	•				lental Hy	giene	0011	1020	0
			Registrar  1. Decedent's Name (First	st, Middle, Lasi	t)	<del></del>	Cen	rificate c	of Death	_	2. Date of De	Reg. No.	1011	3. Time of Deat	h
per .	Physicia Medic	al	Jacquelin	ne Har	tman						JUNE	O4	- 201	11:01	AM
•	Examin	er	4a. Facility Name (if not in	nstitution, give : Ospital	^ -	timor	4		n, or Location		tu	4c.	County of De	imore	
	Funeral Director		5. Social Security Numbe 219-44-734	er 6. Se			st birthday) Yrs.	If Under 1 Y		er 24 Hrs.	8. Date of Bir		9. B	irthplace (State or Fortountry)	eign
			Usual Residence of Dece	edent							- 05/0	3712			_
	aryland ta-f sho ified at	ector	MD 10a. State 10b.	Harfo:	rd		Town or Loc 111stc							10d. Inside City Lin 1 ☐ Yes 2X	
1	vith the M 23a or 28 ist be not	Funeral Director	10e. Street and Number	Lston 1	Road			10f. Zip Co	de 047			_	izen of What C	Country?	_
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status  1 □ Never Married 2  3 ※ Widowed 4 □		12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	Ever in U.S	If	/as Decedent Yes, specify (	Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify:		
15-(	72 hou n "nati ledica	Completed		Decedent's Econly highest gra			(Give k	ent's Usual Od	one during mo	st of work	ing	16b. Ki	ind of Busines	s Industry	
212	within giene. er thar t, the N		Elementary/Seconday 5yrs	y (0-12)	College (1-4 or	5+)		NOT use reti emake					Homem	aker	
Maryland	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Kenneth B		gton				18. Mot	her's Nam Faye	e (First, Middle,	Maiden S	Surname) UNK		
	nd 2 shoul saith and I n 27 is ma		19a. Informant's Name/F Tena M. F	Relationship (Ty) Ripley	<sub>pe, Print)</sub> Daughte	er	19b. Mailing 7585	Address (Str	reet and Num Lane	ber or Rura Apt	G Bal	r, City or Limo	Town, State, 2 ore MD	Zip Code) 21222	
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Dispositio 1 ☐ Burial 2 ☐ Cr 4 ☐ Donation 5 ☐	remation 3 🗆		20b. P At I	lace of Disposemetery crem antic	ition (Name o atony or other Creft	f place)		Date 07/11			or Town, State nie MD	
Balt	permit. Departr Import any inji		21. Signature of Funeral	Service License	ee ·		22. Th	Name and A	ddress of Fac	PA 70	plici 90 Ri	ty C ige	rem & RD Ha	Fun Ser nover MD	V
d	Pnysician/ Medical Examiner		23a. Part 1. Enter the dis shock, or heart fail. Immediate Cause (Final disease or condition resulting in death)	sease, or comp ure. List only or	ne cause on each lin	a conseq	Ocardi	al inf	arction		or respiratory ar	rest,		Approximate Interval Between 3 Onsat and Death 3 Vears	
	ate be executed bhysician and the burial-transit	dical Examiner	Sequentially list condition of any, leading to immed cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	iate	b. Due to (or as	a consequ	ence of):	(01)							
120	ficate t g phys			_	d							_			
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director. After this certificate has been signed by the attending bhysician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	hs?	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	Ideath 3	Ectopic preg Other (specif	nancy jy)				23d. Date of o Month	lelivery Day Year	
P.O.	that the	by Pt	Part II. Other significant			_					23e. Did t	obacco u	se contribute	to the cause of death?	)
rds,	equires een sig nould b	eted	Type II Die	abetes /	mellins,	Cong	estive	Heart	tailu	re			□ No 3 □		own
Reco	The law rate has b	Comple									24a. Was auto perfo	psy ormed2	prior to death?	autopsy findings availa completion of cause es 2  No	
ital	sician: certific rector,	Be	25. Was case referred to examiner?  1 \sum Yes 2 \sum No	17	Hospital:				6. Place of De						
of V	g Physer this reral di	e: To	27. Manner of Death		28a. Date of inju	iry	ER/Outpatient 28b. Time of	28c.	4 ∟_ Injury at		ome 5 🗌 Resi 28d. Describe I			ecify)	
Division of Vital Records,	l or Attendin after death. Director: Aft in by the fur	Certificate:	2 Accident	Pending Investigation Could not be determined		ury - At ho	injury me, farm, stre	М	work? 1  Yes 2	□ No	28f. Location ( City or Tox			Rural Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fo	Medical	(Check 2 🔲 N	Medical Exami	ician: To the best of ner: On the basis of e e Practioner: To the	examination	and/or investi	gation, in my o	pinion, death	occurred at	t the time, date	and place,	, and due to the	e cause(s) and manner	state
	Neith Con		29b. Signature and title of	OR.	Bm	$\bigcup$			RES_				ne signed (Mor		
			30. Name and address of Pavid R. Be		ompleted cause of o	death (Item	23a) (Type, Pi	tal of	Baltim	ore					
	Sta Registra		31. Date filed (Month, Da		\$2. Registr	ar's Signat	fare	w							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Eugene C. Johnsor	n, Jr. 1- For State Registrar	State of Maryl		rtment of tificate of		Mental F		20 i	18300
Physician/ Medical Examiner	1. Decedent's Name (First	_		Johnso	n Jr.		2. Date of Dear Month June 5, 20	th Day Year	3. Time of Death 0336 hrs
	4a. Facility Name (if not in	stitution, give street and n  @ South of Wilson	umber)		c. City, Town, or L Ft.Washingto			4c. County of Dea	
Funeral Director	5. Social Security Number 219-76-103		7. Age (In yrs. la 54	nst birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mi	s. 8. Date of Bir	th(MM/DD/YYYY) 9. E .15 , 1957	Birthplace (State or eigh Wash Country)DC
uith the Maryland 23a or 23a-f show any notified at once. al Director	Usual Residence of Deceding 10a. State 10b. C Pr 10e. Street and Number			Town or Location	n 10f. Zip Code		[1	0g. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No
nith the Ma 1,23a or 29 1 notified 1	7954 Priya		cedent Ever in U.	S 13 Was	20110 Decedent of Hisp	anic Origin? ( 5		USA	erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "matural", or items 23a or 23a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 3 Widowed 4	Married Armed F 1 X Yes Divorced If Yes, Give Ye or Dates:	Forces? 2 No	If Ye	s, specify Cuban, res 2 No	Mexican, Puert specify:	o Rican, etc.)	White, etc.	ack
5-0036 ed within 72 hours tygiene. other than "natuu the Medical Exam Completed	15. Decedent's Education  Elementary/Secondary  1 2	n (Specify only highest gra (0-12) College (	1-4 or 5+)	during mo	S Usual Occupation of working life. I	DO NOT use re		Dept Of	
Baltimore, MD 21215-0036 oemit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medical To Be Comple		Johnson S	Sr.	19b Mailing		Yvonne	Proc	Maiden Surname)  Or  Stor  Stor  Stor  Star  Sta	te Zin Code)
, MD 21 and 2 should aslth and Me on 27 is ma raumatic every	Nakita Joh	nson-Daugh		1306		ane Bl		rg, Va. 24	060
timore, t. Pages la tment of He reant: U ite	1 X Burial 2 Cre 4 Donation 5 Ot	mation 3 Removal f	rom State C	rematory or other	memori Memori	al 6-	11-11	Centrevi	lle,Va.
	21. Signature of Funeral S  Robert  23a. Part I. Enter the disea	B Bale of	V	260	5 S.Sh	ırlıng	ton Rd	neral Ser Arlingto	vice n, Va. 22206
Physician /Medical Examiner	failure. List only one Immediate Cause (Final d or condition resulting in de	cause on each line. isease a. Head and	Neck Injuries a consequence of		mode or dying, s	uch as cardiac	or respiratory and	est, shock, of fleah	Between Onset and Death
miner	Sequentially list conditions if any, leading to immedial cause. Enter Underlying (	te Due to (or as Cause c.	a consequence of						
0, sician and burial - transit edical Examiner	events resulting in death)	d	a consequence of	):					
	UNPENDED  IF FEMALE:	AMENDED 23c. If yes,	outcome of pregr	nancy				23d. Date of delive	ery
). Box 68760 the death certificate by the attending physiched for use as the bupysician/Me Physician/Me	23b. Was decedent pregna past 12 months?  1 Yes 2 No 9	1.	nant at time of dea	ath T	I death 3	_Ectopic pregn	ancy	Month	Day Year
s, P.O. Be ires that the de signed by the 1 be detached f	Part ii. Other significant	conditions contributing	to death but not re	sulting in the un	derlying cause giv	ven in Part I.			obably 4 Unknown
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b ledical Certification: To Be Completed by Physician/Me					00 Pl		1 Yes	psy prior to rmed? death?	
f Vital Physician r this cert ral director	25. Was case referred to rexaminer?	Hospital:	Inpatient 2	ER/Outpatient		of Death (Check		Residence 6 🗸 Oth	er: Scene
tion of tending Placeth.  tor: After y the funeral	27. Manner of Death  1 Natural 5  2 Accident	Pending Jun 5, 2	of Injury h Day,Year) 2011	28b. Time of Inj 0315 hrs	· I _ ·	at Work? es 2 ✔ No	Driver in an	how injury occurred auto to auto colli	
Division or strending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral edical.		determined (Specify	ce of Injury - At ho  Major Road	I / Highway			or Town, S North Route 2	state) 210 @ South of Wils	Rural Route Number, City son Brige , Ft.Washingt
To the Hospital within 24 hours: To the Funeral completely filled	(Check only one) 2 Medic	ring Physician: To the be ai Examiner:On the basis and manner	of examination ar		n, in my opinion,	death occurred		and place, and due to	the cause(s)
	29b. Signature and title of Pamele Type	thall, mo			29c. License O.C.M			29d. Date signed (N	ionth, Day,Year)
,	30. Name and address of Pamela E. South		ise of death (Item Medical Exar		W. Baltimore	Street, Balt	imore, MD 2	1223	
State Registrar		,Year) 32. R	egistrar's Signatur		_				

Please Type or Print in Black Indelible Indeli Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2020 Ola Mae Johnson 20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Union Memorial Hospital **Funeral** 5. Social Security Number 437–22–7970 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min. Month, Day, Year)
May 27, 1922 Director 89 Louisiana Usual Residence of Deceden or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must hammer and 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Marvland N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1601 Mt. Royal Avenue 21217 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify. Specify. Black 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Salon Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Not Available Mattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Calhoun 932 Central Avenue Baltimore, Maryland 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/09/11 Owings Mills, Md. Garrison Forest Veterans Cemetery one of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. **Eutaw Place Baltimore Md** 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): executed and resulting in death) Last Due to (or as a consequence of): burialthe attending physician hed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 month Day Pregnant at time of death 5 Other (specify) Month Year ate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has performed Yes 2 No 1 Yes Be 25. Was case referred to predical 26. Place of Death (Check only one) Hospital မ 1 🗌 Yes 2 No Other: 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of Certifying Nurse Practioner: To in examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 e best of my kno wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi-29d. Date signed (Month, Day, Year, 110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 31. Date filed (Month, De State Registrar

11-03689 John Steven Jure		State of Maryland / Department of Health and Mental's		gible. 2011	1830
Physiciar		1- For State Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	eg. No. th	3. Time of Death
Medical Examin	-	John Steven Jurewicz	Month May 16, 2	Day Year 011	1530 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat 4998 Dorsey Hall Drive #B4 Ellicott City	th	4c. County of Death Howard	n
Funeral Director		5. Social Security Number UNK 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	_	th(MM/DD/YYYY) 9. Bir 5 / 1 9 5 5 Foreig	
and show any acc.		Usual Residence of Decedent  10a. State			10d. Inside City Limits
death with the Maryland or items 23a or 28a-f show must be notified at once.	2	10e. Street and Number 4998 Dorsey Hall Drive B4 21042	11	0g. Citizen of What Cou USA	ntry?
after death with 11", or items 23 ner must be n	Lue	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Plates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Was Decedent of Hispanic Origin? (S 15. Was Decedent of Hispanic Origin? (S 16. Was Decedent of Hispanic Origin? (S 17. Was Decedent of Hispanic Origin? (S 18. Was Decedent of Hispanic Origin? (S 19. Was Decedent of Hispanic Origi		White, etc.	ite
036 ithin 72 hours nne. r than "natur.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use reference to the complete of the comp	work done tired)	16b. Kind of Business/l	
MD 21215-0036 ad 2 should be filed within 7 alth and Martal Hygiene. and 2 is marked other than 2 wamatic event, the Medica	8	Stanley Jurewicz Rose	•	Maiden Surname) UNK	
MD 21 d 2 should d 2 should ith and Me a 27 is ma	-[	19a. Informant's Name/Relationship (Type, Print)  Frank Latoraca Auth Agent  512 Bookout Road			
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiers and "antural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign of Funeral Service Licensee  22. Name and Address of FacilitySim	Date 5/01/11 nplicit	y Crem &	rnie MD Fun Serv
Physician /Medical £xaminer	1	23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular Disease or condition resulting in death)	or respiratory arre		Approximate Interval Between Onset and Death
ted unsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
2 P 2 -	= L	Due to (or as a consequence of):  d.  AMENDED   AMENDED			
_ O T C T		IF FEMALE:  AMENDED 23a, 27, per me, g916 6-10-11 sm  23c. If yes, outcome of pregnancy		23d. Date of delivery	
box 68760, the death certificate be except the attending physician a chef for use as the burial -	y sicially	3b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown	ancy		ay Year
P.O. res that signed be deta	3	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	_ I	bacco use contribute to	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.  To the Funceral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the building or certification: To Be Completed by Divisional Management of the Divisional Man		25. Was case referred to medical 26 Place of Death (Check	24a. Was a autops perform	sy prior to c m <u>ed</u> ? death?	opsy findings available ompletion of cause of S
/ital				Residence 6 🗸 Other	Scene
tending Pheath.  or: After the funeral	1 2	27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending		ow injury occurred	
Division of To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune ordinal Centification:		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S or Town, St	treet and Number or Rur ate)	al Route Number, City
To the Host within 24 hc To the Funs completely defined to the Funs completely desired to the Functional Completely desired to the Function Completely desired to the Functional Completely desired to the Functional		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and core 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
	2	29b. Signature and title of certifier  O.C.M.E.		29d. Date signed (Mon	th, Day, Year)
	3	30. Name and address of person who completed cause of death (Item 23a)	1222		0.00

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day, Year)

JUN 0 9 2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ry Miles Jaco	bs	St 1- For State Registrar	ate of Maryl			nt of I te of D		nd Me	ntal Hy		eg. No. 20		18303
Physicia		Decedent's Name (First, Middle, Last)								2. Date of Deat Month	Day Year		Time of Death
dical Exami	ner	•								May 27, 2	011		2207 hrs
		4a. Facility Name (if not institution 1905 1/2 Rushley Roa		umber)			City, Town, o Parkville	r Location	n of Death		4c. County of Baltimore	Count	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		day) Yrs.	If Under 1 Ye		nder 24Hrs. urs Min.	8. Date of Bir 07/24	th(MM/DD/YYYY) /1951	Foreign	ry) MD
		Usual Residence of Decedent				1							
id how any ce.	L	MD 10b. County Balt	imore			Location							Od. Inside City Limits  Yes 2 No
<b>215-0036</b> Se filed within 72 hours after death with the Maryland tall Hygiene.  **Red nither than "natural", or items 23a nr 28a-f shown int, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1905 1/2 Rus	shlev Ro	ad		1	0f. Zip Code 21.2	34		1	Og. Citizen of Wha	at Country	<i>l</i> ?
h with th ems 23a I be noti	neral [	11. Marital Status  1 Never Married 2 M	12. Was De	cedent Ever in	U.S.			ispanic O		ecify Yes or No			n Indian, Black,
after deat	by Fur	3 Widowed 4 X Div	1 Yes	2 1 No		1 Y					Specify:	Whi	te
hours natur Exam		15. Decedent's Education (Spe	cify only highest gra				Usual Occupa of working life				16b. Kind of Bus	iness/Ind	ustry
215-0036 be filed within 72 rtal Hygiene. -ked nther than " ent, the Medical I	Completed	Elementary/Secondary (0-12) 12yrs	College (	1-4 or 5+)		Carp	enter				Const	ruc	tion
15-00 filed wit Hygien duther		17. Father's Name (First, Middle,	•								Maiden Surname)		
121 Id be fi Mental J narked event,	o Be	J. Earl Jaco  19a. Informant's Name/Relations			119h	Mailing A	ddrass (Stra				eubeck	State 7	in Code)
AD 2 shou h and h and h	7	Myrtle L. Ja		other							kville		
s 1 and of Health		20a. Method of Disposition				Disposition	on (Name of ce	emetery,	T	Date	20c. Location -	City or To	wn, State
Pages lent of int: M		1 Burial 2 Cremation 4 Donation 5 Other S		rom State			Crem		06,	/03/11	Glen H	Burn	ie MD
Baltimore permit. Pages 1 a Department of He Important: If it		21. Signature of Funeral Service											Fun Serv
Physician	-	23e. Part I. Enter the disease, or		caused the deat	th. Do not	enter the	masal mode of dying	Len, such as	PA / ( s cardiac or	respiratory arm	age RD est, shock, or hea	rt .	over MD Approximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Tramad	ol and		ocodo	ne Int	oxic	ation				Between Onset and Death
	-	Sequentially list conditions, if any, leading to immediate	b	a consequence								$\dashv$	
	Examine	cause: Enter Underlying Cause (Disease or injury that initiated	C	a consequence									
executed an and al - transit		events resulting in death) Last	d					016					
E. E. &	edical	■ UNPENDED		23a,27		-i , pe	r me,g	916	6-17-	ll sm			
<b>Records, P.O. Box 68760</b> , The law requires that the death certificate becate has been signed by the attending physispage 2 should be detached for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Uni	ne 1 Live	nant at time of o	2		death 3	Ecto	pic pregnar	ncy	23d. Date of o	delivery Day	y Year
ires that the de signed by the detached f	by Ph	Part II. Other significant condit		to death but not	resulting	in the und	lerlying cause	given in	Part I.	I	bbacco use contrib	_	e cause of death?
w requires is been sig		-								24a. Was	an 24b. W	ere autop	osy findings available
	Completed									perfo 1 <b>✓</b> Yes	rmed? de	eath? ✔ Yes	2 No
/ital sichan is certi lirecto	Be	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Out	patient 3		Other <sub>4</sub>	th (Check o		Residence 6	Other: S	cene
n of Vii ding Physic  After this funeral dire	on: To	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Death	(Mont	e of Injury h, Day,Year)		me of Inju	iry 28c. Inj	ury at Wo	ork?		how injury occurre		
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifiely filled in by the funeral director,	Certification	2 Accident Inve	stigation 28e. Pla	-27-11 ce of Injury - At	home, far	:55 p	m		etc.	or Town, S	Street and Numbe	r or Rural	Route Number, City
	edical Cer	29a. Certifier (Check only 1 Certifying P	hysician: To the be miner: On the basis		edge, deat				place, and	due to the caus	Le, Md.	as stated.	-
Ta the within To the comple	Medi	29b. Signature and title of certific	and manner		STOROL III	. Jonganoi	29c. Licen			ano, date	29d. Date signe		
	1	mych	10, V=	2				.M.E.			May 28, 20		
		30. Name and address of person Ling Li, MD Assista	who completed cau ant Medical Exa			ltimore	Street, Ba	Itimore	, MD 21	223			
St	tate	31. Date filed (Month Day Year)	32. R	egistrar's Signa		11							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of De Physician/ 201 Tear June June 5 P John Krebs Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Glen Burnie 99 Mary Lane Apt 203 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Age (In yrs. last birthday) (Month, Day, 1 🕅 M 2 🗆 F Hours Min. Maryland Mar. Director 51 216-74-1032 Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 🗌 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 USA 99 Mary Lane Apt 203 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene, item 27 is marked other than "natural", or Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene, Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed/Electrician Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances E. Combs Charles Louis Krebs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 99 Mary Lane Apt 203 Glen Burnie Maryland 21061 Sherry Ramsey-Fiance' 20a. Method of Disposition \_ulcn\_ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State ukn ukn Date Page 1 cemetery, crematory or other place) Brooklyn Park, Maryland 4 Donation 5 Other (Specify) June 14,201 Hill Cemetery 22. Name and Address of Facility Ambrose Funeral Nome Inc. 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ wa disease or condition Medical resulting in death) **Examiner** Chronic obstructive pulmonam Sequentially list roadillors if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Pleuval Exami burial-transi and Due to (or as a consequence of) resulting in death) Last Castoesoxhageal reflux disease physician s the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Hospital or Attending Physician: The law requires that the death 24 hours after death.
24 hours after death.
Funeral Director: After this certificate has been signed by the attereted filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Division of Vital Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Osteoporosis 24b. Were autopsy findings available prior to completion of cause of autopsy death? ☐ Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) D56950 June 6,2011 P.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1411 Madison Park Drive Suite IL Glen Burnie MD 21061

Registrar

State

Aggiely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician/ 2011 525 am therine Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wast Jove H min If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Feb 26 1 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 68 **Director** 216-40-1481 1943 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 🗆 Yes 2 🛣 No MD Sykesville Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral items 23a 6425 Tamarack Circle 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Elizabeth Linnbaum Joseph Thomas Mehl, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6425 Tamarack Circle, Sykesville, MD 21784 Joseph A. Klein, III (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremation 3 Removal from State All County Cremation 5-26-11 Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel Signature of Funeral Service Licenses tredret though roude P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final 20 Physician/ disease or condition Medical resulting in death) Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month: 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation pleted filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

DHMH 17 Rev 7/2009

Registrar

State

Medical

29a. Certifier

only one)

3 🗆 29b. Signature and title of certiful

ROBERT RICE MD.

31. Date filed (Month, Day, Year)

JUN 0 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5555. CENTER ST.

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WESTMINSTER

MD 21157

Fu Dir permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Phys Me Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending physician and Division of Vital Records, P.O. Box 68760

		_ For	ase Type of State				K. Ensure A Health and N	=		egible.	
		1 - State Registrar	u 1 41		Cer	tificate of L	Death		Reg. No.2	011	18306
nysicia Medic		1. Decedent's Name (First, Mida Margaret	F		Krebs			2. Date of De June	<b>D</b> ay	2011	3. Time of Death 6:35 P M
xamin	er	4a. Facility Name (if not institution 3021 4th Av	n, give street and r enue	umber)		4b. City, Town, or Parkvil	Location of Death			unty of Death Cimore	
ineral ector		5. Social Security Number 219-01-5011	6. Sex 1 $\square$ M 2 $X$	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird 03/29/			place (State or Foreign ontp) y land
28a-f show otified at	Funeral Director	Usual Residence of Decedent  10a. State  10b. Count  Maryland Balt	,		ty, Town or Loc	cation	<u>-</u>				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
s 23a or 3 ust be no	eral Di	10e. Street and Number 3021 4th A	venue	•		10f. Zip Code 21234			10g. Citizen	of What Cou	intry?
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		11. Marital Status  1 ☐ Never Married 2 ☐ Ma  3 ☒ Widowed 4 ☐ Divorce	12. Was D Armed 1 1 7 If Yes,	ecedent Ever in U.S Forces? es 2 X No Give Dates.	li li	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🙀 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, cify: Whi	etc.
er than "natu the Medical	Completed by		ent's Education lest grade complet College	ed) (1-4 or 5+)	(Give I	O NOT use retired)	ation during most of work	ing	16b. Kind o	of Business In	
narked othe	To Be	17. Father's Name (First, Middle, Harry Benson	Howard, S	ir.			18. Mother's Nam		Maiden Sum	ame)	
m 27 is r ner traun		Norman E. Kre		Son	19b. Mailin		and Number or Rura g Creek W				,
tant: If ite jury or oth		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 4 🗍 Donation 5 🗍 Other		om State	cemetery, crem	sition (Name of natory or other place alley Mer	ce)	Date 0/2011		on - City or T	
any in		21. Signature of Funeral Service	Sus Sus	lis		. Name and Addres	ss of Facility Ton Funera	owson, 1 Home,	MD 212 Inc.	04 1050 Y	ork Road
ician/		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	CON	GESTI		g, such as cardiac o		rest,		Approximate Interval Between Onset and Death
miner	7	Sequentially list conditions,	b. ——	to (or as a consequ							
burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	<b>S</b> c	to (or as a consequence to (or a conseq	<u> </u>	, 20					
buris	g	and the second s	d		· ·	ARTERT	DISEAS	6			
to the function. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 🗆 Li 4 🗆 P	outcome of pregna ve Birth 2  Feta regnant at time of a nknown	al death 3	Ectopic pregnand Other (specify)	у		23d.	Date of deliv	very Day Year
isigned by	۵	Part II. Other significant condit	ions contributing t			nderlying cause giv	ven in Part I.				he cause of death?
age 2 shou	Completed							24a. Was autop perfo	osy ormed?	prior to co death?	opsy findings available ompletion of cause of
erunce ector, p	Be	25. Was case referred to medica examiner?				26. Pl	ace of Death (Check	1 🗌 Yes	Z/S NO	1 L Yes	2 L NO
funeral dire	cate: To	1 Yes 21 No  27. Manner of Death  1 Natural 5 Pend 2 Accident Invest	28a. Da	Inpatient 2 Late of injury fonth, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Injun work	4 □ Nursing Ho / at	ome 5 Residence 28d. Describe h			y)
d in by the	Certificate:	3 Suicide 6 Could	not be 28e, Pla	ice of Injury - At ho ilding, etc. (Specify				28f. Location (S City or Tow		mber or Rura	l Route Number,
pleted fille	Medical	(Check 2 ∟ Medical	Examiner: On the	basis of examination	n and/or invest	igation, in my opinic	, date and place, an on, death occurred at e time, date and place	the time, date a	and place and	I due to the ca	suse(s) and manner stated
M comp		29b. Signature and title of certific		1/ 17.0	_	29c. License			29d. Date siç	gned (Month,	Day, Year)
) A.		30. Name and address of person	who completed of	use of death (Item	123a) (Type, P	rint) T. Pierra	DR TI	iw son	21204		
Stat egistra		31. Date filed (Month, Day, Year)  O JUN 0 9	2011	Registrar's Signa	Je fa	N			- 10 - 1		

			_ For	Pleas	e Type or Pri State of M										le.	
		-	State Registrar					tificate					Reg. N	7111	MANAGEMENT .	18307
	Physicia	n/	1. Decedent's Name				_					2. Date of D	, D	ay 20 J	ar	3. Time of Death 7:30 A M
J	Medic	al	Melvin R		ve street and number)			4b. City,	Town, or	Location	of Death	June	4	c. County of [		7.30 A
	Examin	er	Stella M		, ,				oniu							more
	Funeral Director	0	5. Social Security Nu.	029	Sex 1 X M 2 □ F	e (In yrs. Ia	st birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D Jan. 1	irth lay, Ye <i>ar)</i> 5 19	918	Birthpl Countr M	ace (State or Foreign
	nd show at	'n	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
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	th the 3a or 2 the no	Funeral Director	10e. Street and Nun		-to Mar			10f. Zip	Code 2103	ın.			10g. C	itizen of Wha	t Count	ry?
	ath wii ems 2 r musi	uner	10525 Wi	TIOM AT	12. Was Decedent	Ever in U.S	5. 13.				rigin? (Spe	cify Yes or No Rican, etc.)	<u> </u>  -	14. Race - /	America	n Indian,
ဖွ	ter de , or ite		1 Never Marri		Armed Forces?  1 Yes 2 Yes If Yes, Give	No		If Yes, spec				Rican, etc.)		Black, V Specify:		tc. hite
003	ours af tural" al Exa	Completed by	3 XWidowed		Year or Dates.						y.		10	Kind of Busin		
75	an "na Medio	mple	(Spe		grade completed)  College (1-4 or	5.1	(Give	dent's Usua kind of wor O NOT use	k done c	during mo	st of worki	ng				•
212	withir giene ner tha t, the		10		n/a	J+)	Food	Brok	er					ood/Su	pern	narket ————
A.M. Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (i								her's Name ephir	e (First, Middle ne V.			у і	nformant)
A.M Man	shoul and 7		19a. Informant's Na	me/Relationship	(Type, Print) y, Jr/Son									or Town, State		
:30 A	and 2 Health tem 2;		20a. Method of Disp		,, 02,000	20b. P	lace of Dispo	osition (Nan	ne of			Date		Location - Cit		21030 wn, State
7: mor	age 1 ent of nt: If i			Cremation 3	Removal from State	7	emetery, crei ood1aw	-			6/8/	11	Wo	odlawn	, MI	)
7:30 Baltimore,	permit. F Departm Importal any injul	10 15	Bryan	ryce Ly	insel Aud	-					Home	e of Du	ılan	ey Val MD 210	1ey 93	, Inc.
			23a. Part 1. Enter t	te disease, or co	omplications that couse y one cause on each lin	d the deat										Approximate Interval Between
9~	Physician/	2	Immediate Cause (	Final	N.	EME	NTI	4							13	Onset and Death
4	Medical Examiner		resulting in death)	4	Due to (or as	a consequ	ience of):									- 1
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11	executed an and rial-transit	Examiner	cause. Enter Unde Cause (Disease or that initiated event	rlying iinjury	C										- 5	<u></u>
7			resulting in death)		Due to (or as	a consequ	uence of):									
207	ate be physic the bu	gic			d										$\pm$	
JUNE 4, 201 P.O. Box 68760	requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome			Catania	Dress 0.00					23d. Date of	of delive	ry
BOX	death le atte	sicia	in the past 12 1  Yes 2	months?	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	at time of o		Other (s		-у				Month	1	Day Year
JUNE O. Bo	at the day the estache	Phy	9 Unknown		s contributing to death		ulting in the	underlyina	cause di	ven in Pa	rt I.	23e. Dio	tobacco	use contribu	ite to th	e cause of death?
	res that signed albe d	d by		ONARY	BRIER	N D	ISET	SE						١		ably 4 🗆 Unknown
org	requi been should	Completed				1						24a. Wa		24b. Wei	re autor	sy findings available
Zec.	he law te has age 2	J L										aut per 1 \sum Yes	topsy formed? s 2	dea	th?	npletion of cause of 2  No
KENNEY VItal Re	sician: The law I s certificate has k lirector, page 2 s	BeC	25. Was case referr	ed to medical							eath (Checi					
KE	Physic this ce al dire	은		No	Hospital: 1  Inpa 28a. Date of inj		ER/Outpatie		OA Oth	4 10		ome 5 Re		6 Other (	Specify)	
NI	ding I th. After funer	cate	1 Natural 2 Accident	5 Pending Investiga	(Month, D	ay, Year)	injury	M	worl			Zod. Describe	e now inj	ury occurred		
MELVIN KENNEY Division of Vital Records.	or Atten after dear Director: I in by the	Certificate:	3 Suicide 4 Homicide	6 Could no determin	ot be			reet, factor	y, office	_		28f. Location City or To			or Rural	Route Number,
۵	Hospit 24 hour Funera	Medical	(Check 5	Medical Fy	Physician: To the best of aminer: On the basis of Jurse Practioner: To the	examinatio	n and/or inve	stigation, in	my opini	on, death	occurred a	t the time, date	e and pla	ce, and due to	the cau	ise(s) and manner state
	To the within to To the comple	Σ	29b. Signature and		O	A A	, 1010 mouge,	290	c. Licens	e number	r	,	29d. [	Date signed (A	Month, L	Day, Year)
4	,		1 gu	stine	Jrew Ch	CAP			KO	433	380		0	6/06	120	11
	N				no completed cause of		n 23a) (Type, DULANE)		T.FV	ROZ D	TTM	ONIUM,	MD	21093	3	
	Cto	to	JUST.			rar's Signa		· VAL	T (11)	NOAD	7.11	.0211 041 /				
	Sta Registr		JUN 0 9													

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			riease					K. Ensure A	•		0	
		For State Registrar		State of	iviai yiai		tificate of i	Health and N Death		/		18308
		Decedent's Name (First	st, Middle, La	st)			Timeate of I	Douth	2. Date of De	Reg. No.		3. Time of Death
Physicia Medic		Charles V	. King						Month May 3	0, Day	011 Year	5:55 PM <sup>M</sup>
Examin	er	4a. Facility Name (if not in			per)		1	or Location of Death			County of Death	
Funeral		Gilchrist  5. Social Security Number			7. Age (In yrs. la	ast birthday)	Tows		8, Date of Birt	th	Baltimor	nplace (State or Foreign
Director		220-14-98	124	X M 2 □ F	86		Months Days	Hours Min.	Jan 30	y, Year) 19	25 Mary	yland
land show dat	'n	Usual Residence of Dece 10a. State 10b	. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Aaryla 8a-f s tified	rect	MD B	Baltimo	re		Balti:	more					1 ☐ Yes 2 ☑ No
h the la or 2 be no	a Di	10e. Street and Number			<u>'</u>		10f. Zip Code			10g. Citi	izen of What Cou	untry?
s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	4502 Fulle	erton A	Venue	ant Front in 116	C 110 1	212		- if . V N.		USA	
ter des or ite miner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2</li></ul>	2 Married	Armed Ford	ces? 2 👿 No	It	f Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto	Rican, etc.)		14. Race - Amer Black, White	
ursafi tural", al Exa	ted	3 X Widowed 4 □		If Yes, Give Year or Dat	es.		☐ Yes 2🌠 No	Specify:			Specify: b1	ack
72 ho n "nat	Completed	(Specify o		ade completed)		(Give I	lent's Usual Occup kind of work done O NOT use retired)	durina most of work	ing	16b. Ki	nd of Business I	ndustry
within giene.	S	Elementary/Seconday	y (0-12)	College (1-4	1 or 5+)	1	sembler			Ge	neral M	otors
e filed tal Hy ed oth event	To Be	17. Father's Name (First,						18. Mother's Name			,	
d Mer d Mer marke		Charles F				T 401 14 111		Dorothy				
ge 1 and 2 should be filed within 72 hours after death with the Maryland rt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		Eric King		ype, Fillitj		4502	g Address (Street Fullert	and Number or Rura on Avenue	Baltim	r, City or lore,	Town, State, Zip MD 21	<sup>Code)</sup> 236
e 1 an t of He If item or othe		20a. Method of Disposition		Removal from S			sition (Name of natory or other place	ce)	Cate	20c. Lo	cation - City or T	rown, State
permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		4 🛛 Donation 5 🗌	Other (Speci	fy)								
Depa Impo any i		21. Signature of Funeral	Service Licens	Wade, D	irector		Stated Adda Baltimore	ਵਿਲੀਜ਼ਿੰਨ੍ਹਾਂ।itBoar , MD 212		. Ва	ltimore	Street
RED.		23a. Part 1. Enter the dis	sea e, or com	plications that ca	used the deat h ine.	h. Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory arr	est,		Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		a Blay	der	Carr	el					Onset and Death
Examiner		resulting in deating		Due to (o	r as a consequ	uence of):						
- 5	ner	Sequentially list condition if any, leading to immedicause. Litter Undanying	ons, iate	b. Due to (o	r as a consequ	uence of):						
cuted ind transit	Examiner	Cause (Disease or linjury that initiated events		c						_		
be executed sician and burial-transit	calE	resulting in death) Last		Due to (o	r as a consequ	ience ot):						
ficate g phys				d	-							
h certi tendin r use a	an/	IF FEMALE: 23b. Was decedent pregr in the past 12 month		23c. If yes, outco	ome of pregna irth 2  Feta		Ectopic pregnanc	CV		2	23d. Date of deliv	/ery
e deat the at hed fo	by Physician/Med	1 Yes 2 No		4 Pregna 9 Unkno	ant at time of cown	leath 5	Other (specify)				Month	Day Year
that th	된	Part II. Other significant	conditions c	ontributing to dea	ath but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco us	se contribute to t	the cause of death?
quires en sign	ted t								1 🗆 🗎	Yes 2	□ No 3 □ Pro	obably 4 Unknown
law rec nas be	Completed								24a. Was a	sy	prior to co	opsy findings available ompletion of cause of
r: The icate h		05. Was assessed to			-					rmed? 2 No	death? 1 🗌 Yes	2 🗆 No
sician s certif lirector	e Be	25. Was case referred to examiner?		Hospital:			LOth	ace of Death (Checker:			XXi	
ig Phy ter this neral o	te: 70	27. Manner of Ceath		28a. Date of	ipatient 2 injury , Day, Year)	28b. Time of injury	28c. Injur	y at 2	me 5 ∟ Resid 28d. Describe h			o Wift
tendin leath. or: Aff the fur	ifica	2 Accident	<ul><li>☐ Pending</li><li>Investigation</li><li>☐ Could not b</li></ul>	1				Yes 2 No				
	Certificate:	4 Homicide	determined	28e. Place o	f Injury - At ho g, etc. (Specify)	me, farm, stre )	et, factory, office		28f. Location (S City or Tow		Number or Rura	l Route Number,
ospita hours uneral ed fillec	Medical	29a. Certifier 1 Charles 2 D	ertifying Phys	sician: To the bes	st of my knowl	edge, death o	ccured at the time	, date and place, an	d due to the cau	ise(s) and	d manner as state	ed.
the H thin 24 the Fi	_	only one) 3 L C	ertifying Nurs	se Practioner: To	the best of my	knowledge, d	eath occurred at th	e time, date and plac	e, and due to the	cause(s)	and manner as s	
<b>5</b>		29b. Signature and title of	A 🔊	la			29c. License	S 9 20	7	29d. Date	signed (Month,	Day, Year)
	ŀ	30. Name and address of	person who			23a) (Type, Pr	rint)	,,,,,,,		/	700	e <del></del>
		MARON	1 1	UNDE	RJ N	N 6	701 A	Lice	an les	51	Ton	120N MD
State Registra	7	31. Date filed (Month, Day	0 9 201	1 2. Rec	gistrar's Signa	ure fau	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 20°1′1 рм 6:30 John W. Lafferty **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 1241 Haverhill Road If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Months Hours 42774/1933 Mary land Director 213-30-1238 77 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Baltimore 28a-f N/A MD Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral 21229 United States 1241 Haverhill Road ral", or items 2 Examiner mus death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married X Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Yes. Give Specify: White "natural". 3 Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Mechanic Construction Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ျ Lillian Schapell Health and Ment tem 27 is marked other traumatic e Harold Lafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Debra L. Jones (Daughter) 980 Martin Road, Essex, Maryland 21221 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 06/09/2011 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) re of Funeral Service Hubbard Funeral Home, Inc. Avenue, Baltimore, Maryland 21229 4107 Wilkens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical **Examiner** Esquisitiony list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine -tran Due to (or as a consequence of): burialed by the attending physician detached for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 200 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, de

8+1

DHMH 17 Rev 7/2009

State <u>Reg</u>istrar Maiden Choice In. Ste 301

Baltimoro, 1

eted cause of death (Item 23a) (Type, Print)

**Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

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Physician/

Medical

Director

Funeral

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Examine

Physician/Medical

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Medical Certificate: To Be

Examiner

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician/ Medical

physician and s the burial-trans

Baltimore, Maryland 21215-0036

Thomas C. Lyons	Husband	321	variey	Court	Koad	Lutne	ervil.	re, Ma	ryland .	21093
20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispose cemetery, cr	position (Name of ematory or other	place)	Da	ate	20c. Loc	cation - City o	r Town, State	
4 Donation 5 Other (Specify)	iomovai nom otato	Hilltop	Service	Corp.	6-13-2	2011	Tow		-Maryla	nd
21. Significure of the rat Service Lidense	g lun		22. Name and Ac 1050 Yo	rk Roa		Towson,			Home, I 21204	nc.
23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one	ctions that caused the cause on each line.	ne death. Do not er	nter the mode of	dying, such a	s cardiac or	respiratory ar	rrest,		Approxima Interval Be	te tween
Immediate Cause (Final disease or condition resulting in death)		TATIC L	JNG CAN	ICER					Onset and	Death
resulting in death)	Due to (or as a c	onsequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c	onsequence of):								
Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):								
	d									
IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of 1  Live Birth 2 4  Pregnant at ti 9  Unknown	Fetal death 3	Cother (specify	nancy /)			2	3d. Date of d		Year
Part II. Other significant conditions cor	tributing to death but	not resulting in the	underlying cause	e given in Par	t I.				o the cause of c	
CHRONIC OBSTR	UCTIVE P	JLMONAR'	Y DISEA	SE				prior to death?	utopsy findings completion of c	available ause of
25. Was case referred to medical examiner?			26	6. Place of De	ath (Check o		L July 11to			
1 ☐ Yes 2 No	ospital: 1 📈 Inpatien	: 2 ☐ ER/Outpati	ent 3 DOA	Other:	Nursing Hom	e 5 🗆 Resi	dence 6	Other (Spe	cifv)	
27. Manner of Death  1	28a. Date of injury (Month, Day, )	'ear) 28b. Time injury	V V	njury at vork? Yes 2	28	d. Describe h				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (		treet, factory, offi	ce	28	3f. Location (S City or Tov		Number or Re	ural Route Numb	per,
29a. Certifier (Check conly one) 1 Certifying Physic Medical Examina only one) 3 Certifying Nurse	er: On the basis of example	mination and/or inve	estigation, in my o	pinion, death of	occurred at th	ne time, date a	and place, a	and due to the	cause(s) and ma	anner stated.
29b. Signature and title of certifier		Mr	29c. Lice	ense number			29d. Date	signed (Mon	th, Day, Year)	
Kichard	Luth	·cul		D3182			6	-7-	·N	
30. Name and address of person who co	mpleted cause of deat	th (Item 23a) (Type,	, Print)							
PICHORD LINTHI 31. Date filed (Month, Day, Year)	32. Registrar's	75.01 (15 Signature	NER DR	IVE '	TOWSO	N. MA	RYLA	ND 2	1204	

Registrar DHMH 17 Rev 7/2009

State

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

within 24 hours a

JUN 0 9 2011 Denger 1.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IONN LEWANDO	WSKI	1- For State Registrar	e of Maryland		artment of <i>rtificate of</i>		and Mei	ntal Hy	_	eg. No.	201	1 183	31
Physic Medical Exam		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Mouth  Day  Year								3. Time of Death	1		
J. J		John Lewandows k 4a. Facility Name (if not institution, gi		·)		4b. City, Towr	, or Location	of Death	June 4, 20		. County of De		
		Franklin Square Hospital				Rosedal	Э			В	Baltimore C	ounty	
Funera Directo				ge (In yrs. Ia 46	ast birthday) Yrs		Year if Und Days Hou	der 24Hrs. rs Min.	8. Date of Bir July 15	•	TEOR	Birthplace (State or reign Country) MD	
any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Locat	ion						10d. Inside City I	Limits
		MD Baltimo	re		Perry	Hall						1 Yes 2	χNο
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 8719 Silver Hall	Road			10f. Zip Coo	e 21128	3	1		zen of What Co SA	ountry?	
death or ite	Ş	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Deceden Armed Forces 1 Yes 2 d If Yes, Give Year		If Y	s Decedent or es, specify Cu	ban, Mexica	n, Puerto F	ecity Yes or No Rican, etc.)		White, etc.	nerican Indian, Black, hite	
urs aft. tural" nmine	ğ ğ	15. Decedent's Education (Specify of	or Dates:	mpleted)	16a. Deceden				ork done		Specify: W  Kind of Busines		
5-0036 lied within 72 hours after Hygiene, 1 other than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12)	College (1-4 or		during mo	ost of working ${f k}$	life. DO NO	T use retire	ed)		ood Ser		
21215-0036 ould be filed within 7 Mental Hygiene in arrived other than ic event, the Medica	S	17. Father's Name (First, Middle, Las John G. Lewando	•						(First, Middle, I R <b>i</b> char				
D 21215- should be filed and Mental Hyg 7 is marked oth	To Be	19a. Informant's Name/Relationship (			19b. Mailing	Address (S					ty or Town, Sta	ate. Zip Code)	_
MD id 2 sho lith and in 27 is	Γ	Gabrielle S. Le	wandowski	-Wife	17.						11, MD		
S lan of Hea If ite		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from S	c	lace of Disposi rematory or oth	er place)	•	10.11	Date		-	or Town, State	
Baltimore, permit. Pages 1 an Department of Hea Important: If iter injury or other tr		4 Donation 5 Other Specify 21. Signature of Funeral Ferrice List		Но.	ly Cros			6/9/			oklyn P		
Bal permi Depa Impo injur		21. Signature of Funeral Ferrice Class	pisee //	2	Fiin	eral H	ome of	Cate	onsvill	e	Tnc.	b Witzke	
Physician		13a Part I. Enter the disease, or com failure. List only one cause on e	plications that caused	the death.	Do not enter th	e mode of dy	ng, such as	cardiac or	nue: Ca respiratory arre	est, sho	<b>SVILLE.</b> ck, or heart	MD 21228 Approximate Int Between Onset	erval
/Medical Examiner		·	Pontine Hemor									Death	and
		Sequentially list conditions, b	Due to (or as a cons	equence or,	):								
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of)	):								
ed nsit	Examiner	events resulting in death) Last	Due to (or as a cons	equence of)	):							1	
60, nte be executed nysician and e burial - transit	edical	UNPENDED d	AMENDED	-									
760, Icate be physical the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	me of pregn							. Date of delive	-	
Box 6876: death certificate the attending phyed for use as the	Physician/N	past 12 months?  1 Yes 2 No 9 Unknown	1 4	time of dea	ath -	al death er (Specify)	3Ectopi	ic pregnan	cy	'	Month	Day Year	
P.O. Es that the gned by the e detached		Part II. Other significant conditions	contributing to deat	h but not res	sulting in the ur	nderlying caus	se given in Pa	art I.				to the cause of death	
S <sub>1</sub> P.C uires that a signed l	ed by	Hypertensive Atheroscler	rotic Cardiovasc	ular Dise	ase							obably 4 Unkno	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 burs after death.  The Funeral Direct After this certificate has been signed by the attending physician and npletely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Completed				-				24a. Was a autope perfor	sy m <u>ed</u> ?	prior to death?		e of
tal Recian: The certificate ector, page	Be C	25. Was case referred to medical examiner?	Hospital:				ace of Death		, ,				
of Vi Physic Per this eral dir	ဥ	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju		ER/Outpatient 28b. Time of In		njury at Work		Home 5 18d. Describe h		nce 6 Oth	er:	
on of ending P ath. or: After the funera	tion	1 V Natural 5 Pending	(Month, Day,Y	ear)		· ·   _	Yes 2		od. Describe (	iow ingai	y cocumed		
Division ital or Attendi urs after death. ral Director:	Certification:	2 Accident Investigati 3 Suicide 6 Could not determine	be 28e. Place of In	jury - At hor	me, farm, street	t, factory, offic	e building, et	tc. 2	8f. Location (S or Town, St		d Number or R	Rural Route Number,	City
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only 1 Certifying Physic	lan: To the best of m r:On the basis of exa and manner stated.										
H 3 H 3	Me	29b. Signature and title of certifier					ense number			29d, D	ate signed (M	fonth, Day, Year)	
(2)		ひ-ひ-・				0.0	C.M.E.			June	5, 2011		
1 C		30. Name and address of person who Donna M. Vincenti, MD	Assistant Medic	al Exami	iner 900 \		re Street.	Baltimo	ore, MD 212	223			
	ate	31. Date filed (Month, Day, Year)			1. Sa						<del></del>		
Regis	trar	JUN 0 9 2	UTT   Beneu	a l	T. Bar	Kar							

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rotified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State of N Registrar	laryland / Dep Ce	partment of He ertificate of D		ental Hygie Reg.	0011	1831
cian	1. Decedent's Name (First, Middle, Last)  Francis J. Labuda				2. Date of Death	Day Year	3. Time of Death
ical iner	4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or L			4c. County of Deat Baltimor	th
l r	215-70-3724 1\(\overline{x}\) M 2□ F	Age (In yrs. last birthda 74 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb 18,	ear) 9. Birt Co 1937 Mar	thplace (State or Forei ountry) yland
tor	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or I					10d. Inside City Limit
I Director	MD Baltimore  10e. Street and Number  4121 Cliffvale Road	NOT	tingham  10f. Zip Code  2	1236	10g.	Citizen of What Co USA	
To Be Completed by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married   1 ☐ Was Deceder Armed Forces 1 ☐ Yes 2 ☐ Was Deceder 1 ☐ Yes 2 ☐ Yes 3 ☐	3? (1) No	B. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: wh	e, etc.
Completed b	3   Widowed 4   Divorced Year or Dates  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4o	16a. Dec	cedent's Usual Occupa ve kind of work done du . DO NOT use retired)	ıring most of workir		b. Kind of Business/	,
Be Con	0 0 17. Father's Name (First, Middle, Last)	101)	disa	18. Mother's Name	(First, Middle, Maid		
2	John Labuda  19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street a				Zip Code)
0_0	Denise Borkowski/niece  20a. Method of Disposition  1□Burial 2□Cremation 3□Removal from Stat  4ᢂDonation 5□Other (Specify)	20b. Place of Disp	21 Cliffva position (Name of ematory or other place	D		m, MD 21: Location - City or	236 Town, State
dical Examiner	23a. Pat 1. Enter the dise x e, or complications that caus sh k, or heart failur. List only one cause on each Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ed the death. Do not e line.  A IZ    A sa consequence of):	LIA	MD 2120	)1 r respiratory arrest,	,	Approximate Interval Between Onset and Death
hysician/Me		n 2 ☐ Fetal death 3 t at time of death 5	B			23d. Date of del Month	livery Day Year
by P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giver	n in Part I.			o the cause of death? robably 4 \( \square\) Unkno
Completed			· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings availa completion of cause of
Certification: To Be	27. Mann   Death   28a. Date of Ir (Month, L)   28b. Particular   28c. Date of Ir (Month, L)   28c. Place of Ir (Month, L)   2	njury 28b. Time Injury	of 28c Injury Work?	at es 2 \( \text{No} \)	ne 5 1 Residence 8d. Describe how i	et and Number or Ri	
Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the basis and manner	of examination and/or					
Me	29b. Signature and title of certifier  Flese do My		29c. License	number 717	29d.	Date signed (Mont	h, Day, Year)
	30. Name and address of person who completed cause of			DIGI TIHU	MMM	りて	1090
tate trar	JUN 0 9 2011	strar's Sign ture	wed				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Month 28, 1:50 PMM Shirley Mark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Edenwald Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days Min. 1 □ M 2 💢 F Maryland Î927 83 Sept Director Yrs. 207-18-4317 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at by Funeral Director MD Baltimore Towson 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road #912 21286 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes If Yes, Give 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ healthcare 12 psychologist and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Goldie C. Landay Herman R. Alpern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coc 800~Southerly~Road~#912~Towson,~MD~21286permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other tra Henry Mark/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rona I State Anatomy Board 655 W. Baltimore Street MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ remand disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Pregnant at time of death 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy this certificate has al director, page 2 death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

P.O. Box 68760 Records, **Division of Vital** within 24 hours after death.

To the Funeral Director. Af

> State Registra

Medical

29a. Certifier,

29b. Signature and title of certified

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,11,12,15,17,18&19a&b Per ANA BD G916 6/30/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AM M Howard McLaurin 2Ó1 2:00 Medical May 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton 9. Birthplace (State or Foreign 8. Date of Birth 1947 (Month, Day, Year) Aug 17, 2947 Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday, Days Min. 1 X M 2 □ Hours Director NC' 63 246-72-5412 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9106 Pineview Lane 20735 USA filed within 72 hours after death -unk 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Yes 2 No No If Yes, Give 1969-71 Year or Dates. Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black Completed 3 X Widowed 4 Divorced nd Mental Hygiene. marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk unk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 or other traumatic event, Be 17. Father's Name (First, Middle, Last) -unk 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental F ant: If item 27 is marked o ပ Castler McLaurin Viola Morrison 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Stree, and Number or Rural Route Number, City or Town, State, Zip Code)

O.Box 855 Hamlett, North Carolina

Surratts Road Clinton, MD 20735 Fred McLaurin nern Maryl -brother and Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Hamportant: If ite any injury or ot 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 🔀 Other (Specify) <u>in</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board
Baltimore, MD 21201 ixector 655 W. Baltimore Street Baltimore, t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of Exami executed attending physician and for use as the burial-trar a consequence of resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year signed by the a ld be detached f 2 No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No death? 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 🗌 Yes မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending 1 Yes 2 No Investigation Suicide 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of To the test of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K)/ State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Susan Marie Morris	1-For State Certific	ent of Health and Mental F	lygiene
Physician/	Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death
Medical Examiner	Susan M. Morrissey  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	May 25, 2011 1940 hrs
	927 Breakwater Drive	Annapolis	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 - 5 2 - 6 0 4 2 1 M 2 F 5 2	thday) If Under 1 Year If Under 24H Months Days Hours Mi Yrs.	Facilia.
Aaryland 23a-f show any 1at oece. Octor	Usual Residence of Decedent  10a. State	or Location polis	10d. Inside City Limits 1 ☐ Yes 2 🏝 No  10g. Citizen of What Country?
the Maryland in or 28a-f sh iified at occ	927 Breakwater Drive	21403	USA
er death with 1. , or items 23. r must be no	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 X Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puerl	
5-0036 ed within 72 hours aft fygiene. other thae "catural" the Medical Examice Completed by	or Dates:	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	
AD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than matic evest, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Robert V. Daly	18.Mother's Nam	e (First, Middle, Maiden Surname) ne G. Langevin
Ould Me			Rural Route Number, City or Town, State, Zip Code) 1th Taunton MA 02780
•≡ 8 2 ° I I	1 Burial 2 Cremation 3 Removal from State crema		Date 20c. Location - City or Town, State  5/02/11 Glen Burnie MD  Implicity Crem & Fun Serv
	23a. Part I. Enter the disease, or complications that caused the death. Do n	ThomasAllenPA '	7090 Ridge Rd Hanover MD
Physician Medical Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		Between Onset and Death
e secuted cian and rial - transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		
0, be executed sician and nurial - transit	x UNPENDED ☐ AMENDED 23a, 27, per	me,g916 6-10-11 sm	
ox 68 eath certi t attending for use as	past 12 months?	2 Fetal death 3 Ectopic pregr 5 Other (Specify)	23d. Date of delivery  ancy Month Day Year
, P.O. B res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown
Division of Vital Records, P.O. tal or Attection Provides that the real clear. The law requires that the repercent of the this certificate has been signed by led in by the funeral director, page 2 should be detact ertification: To Be Completed by P			24a. Was an autopsy findings available prior to completion of cause of death?  1 ✔ Yes 2 No 1 ✔ Yes 2 No
Vital Recystine: The his certificate director, page	25. Was case referred to medical examiner? [Hospital: 4   legations 2   58/0	26.Place of Death (Check Dutpatient 3 DOA Other, Nurs	
ion of Vi teodiog Physi eath. tor: After this the funeral dir	1 Yes 2 No	Outpatient 3 DOA Outpat Nurs  Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how injury occurred
Division of To the Hospital or Atteoding) within 24 hours after death. To the Favorral Director: Afte completely filled in by the funer ledical Certification:	3 Suicide 6 Could not be determined (Specify)  29a, Certifier	arm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hox within 24 h To the Fuc completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		
W E S E S	29b Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 26, 2011
		r 900 W. Baltimore Street, Balti	more, MD 21223
State Registrar	31. Date filed (Month, Day Year) 22. Registrar's Signature	bare	
DHMH 17 Rev 1/2001		RIGINAL	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 9:30 PM Naomi Pyecha Jean Medical 4c County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** eda ROS 9. Birthplace (State or Foreign Country) West Virginia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2 🖵 F 11/14/1937 Director 215 34 1139 73 Usual Residence of Decedent or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2x No Maryland Baltimore Middle River 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 201 Middleway Road Apt. 3C 21220 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked when any injury or when any injury or when the state of the Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Helen Washabaugh Pyecha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Thomas (brother in Law) 3416 Action Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Belair Mem Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/10/2011 Harford County, Maryland 4 ☐ Donation 5 ☐ Other (Specify) arreral Service Licensee 22. Name and Address of Facility 21. Signa 22. Name and Address of Facility
Bruzdzinski Funeral Home PA
1407 old Eastern Avenue Essex Maryland 21221 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. 23a. Part shoc . Enter the disease, or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emysician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Ectopic pregnancy Day 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy ☐ Yes 2 🗸 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. JUNE, 7, 2011 1 5m Name and address of person who completed cause of death (Item 23a) (Type, Print) Gavare Dr. Balto. MD. 21237 JUN 0 9 2011 Registrar

Vecha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a .26 per doc. 17 per fh .916 6-21-11 yt. State of Maryland / Department of Health and Mental Hyglene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2011 Physician/ Peroutka 8:07 A<sup>M</sup> Theresa June Medical 4a. Facility Name (if not institution, give street and number) S-507 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Mercy Ridge 2525 Pot Springs Rd. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2X F Days Aug. 18,1933 Maryland 219-28-8538 Director or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore 1 🗆 Yes 2 🗐 No Maryland Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 2525 Pot Spring Road, S-507 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 X No 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Martin Smuter Smutek Broczkowska Mary 19a. Informant's Name/Relationship (Type, Print) Frank J. Peroutka 2525 Pot Spring Road, S-507 Husband Timonium, Mary Land 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Stemetery cremetery control place)
Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-9-2011 Fullerton Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road 21204 Towson, Maryland au 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ PANCIEMIL disease or condition CACCINOMA Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No 1 L Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALTERY disc2se 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 A Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: A Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Director Completed filled in b building, etc. (Specify) Medical 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 6/7/11 NICKMELLIS MD D0047762 eted cause of death (Item 23a) (Type, Print) TIMONIUM State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louise M. Reilly JUL 12:20 au 20 Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death Agnes sital 1000 Himor n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. Maryland **Director** 216-03-0028 94 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Fyaminar must have also any injury or other traumatic event, the Medical Fyaminar must have also and injury or other traumatic event. ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Baltimore Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 802 S. Beechfield Avenue 21229 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Medical Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Henschel Ella N. Richard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Leslie / Daughter 802 S. Beechfield Avenue, Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ⊠ Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) Loudon Park Cemetery 6/8/2011 Baltimore, Maryland 21. Si nature of Funeral Service Lice 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ neumonio disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical Records. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Pregnant at time of death Month Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe this certificate 2 No Yes 2 No of Vital within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1/6/11 John o Division o 5 Pending Natural injury Accident Suicide 2 No Investigation 1 Yes Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 25484 who completed cause of death (Item 23a) (Type, Print) 900 15mo JUN 0 9 31. Date filed (Mo 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 200 20 Medical 4a. Facility Name (if not institution, give street and cation of Death 4c. County of Death Town, or L **Examiner** Ca If Under 1 Year If Und 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**.** M 2 □ F Months 6 **Director** 104-18-926 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notflied at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20 1212 12. Was Deceden Ever in U.S. Armed Forces? 1 X Yes 2 \( \square\) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White þ 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Year or Dates. 42-45 Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fabrics-Floral Retail Sales <u>12</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Bowers McLeish Leo W. Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mustang Ct., Lusby, MD 20657 12129 Edith V. Reed (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/10/11 Cumberland, RI Dove Crem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses & A Removal Service C ln, 180 ster pmunk clear brook 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on eye line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death been signed by the a should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes No. 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one, Be examiner? Hospital 1 Yes 💥 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation after death Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature 005226 30. Name and egistrar's S 31. Date filed (N State 9 Registrar

DHMH 17 Rev 7/2009

Cordelia Roberts 11-04218 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Da June 5, 2011 Medical Examiner 0336 hrs Cordelia Roberts 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death North Route 210 @ South of Wilson Brige Drive Ft.Washington Prince George's 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or April 9, 1962 Foreign Wash Country) D.C. 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Hours 229-96-3536 Director 49 Country)DC 1 M 2X F Usual Residence of Decedent 103 10a. State 10c. City, Town or Location 10d. Inside City Limits Va. Prince William Manassas item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at once,</u> 1 Yes 2 X No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7954 Priya Court 20110 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes Specify: Black 3 X Widowed If Yes, Give Year Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event. the No. 20 4 Divorced 1 Yes 2X No specify: 쥴 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Net Work Analysis Fairfax Co. 12 Com 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roberts Sr. Sylvia Robinson Be 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Princess Johnson-Daughter 7954 Priya Court Manassas, Va. 20110 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place Centreville,Va. Robinson Memorial |6-11-11 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chinn Funeral Service <u>covert</u> 2605 S.Shirlington Rd Arlington, Va. 22206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line Between Onset and /Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or Injury that initiated Due to (or as a consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed has been s e 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? this certificate ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 🗹 Other: Scene ۵ 1 Yes 2 No 28a. Date of Injury (Month Day, Year) Jun 5, 2011 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Passenger auto auto collision 0315 hrs

Death

28f. Location (Street and Number or Rural Route Number, City

or Town, State) North Route 210 @ South of Wilson Brige , Ft.Washingt

June 5, 2011

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. within 24 hours a

To the Funeral I

completely filled

Director:

Medical

Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) State

2 🗸 Accident

3 Suicide

Homicide

29b. Signature and title of certifier

5 Pending

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

**OCME** 

32. Registrar's Signature

(Specify) Major Road / Highway

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

1 Yes 2 ✓ No

29c. License number

O.C.M.E.

Registrar

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>20<u>11</u> J<sup>Month</sup> June Physician/ 8 Teresa C. Rynarzewski 8:50aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Longview Nursing Home Carroll Co. Manchester 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 10-6-1926 7. Age (In vrs. last birthday) Funeral 6. Sex 1 M 2 K F 220-12-2856 84 Director Usual Residence of Decedent 10c. City, Town or Location Hampstead Dundalk 10b. County Carroll 10a. State 10d. Inside City Limits Funeral Director or 28a-f sl MD Baltimore 1 Yes 2 X No 10f. Zip Code 5 10e. 2548 O'Id Fort Schoölhouse Road 10g. Citizen of What Country? 21074 must be 23a 6804 Youngstown Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Midowed 4 Divorced "natural" Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than "Imatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Bookeeper United Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Page 1 and 2 should be Michael Hepner Theresa Barszcz and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 21074
2546 Old Schoolhouse Rd. Hampstead, MD MD Health: Linda Skinner/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Important: If any injury or once. Stanislaus Cem. 6-11-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue, Baltimore, 21222 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. erebrovaculax Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. facts, leading to transcript cause. Enter Underlying Cause (Disease or iinjury Examine Dust to for as a consequence of burial-tran attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death signed by the ard d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2: performed? Yes 2 X N 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 K Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No ᅙ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 🗌 Pending injury work?
1 Yes 2 No 2 Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛮 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 06-08-2011 517 30. Name and address of person who completed cause of death (Item 33a) (Type, Print)

Mr. ANSURIVA, 349 Malcolm 0 Mostminster, MD 21157 DR 31. Date filed (Month, Day, Year) 32. Registrar's Bignature State JUN 0 9 2011

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 5, 2011 1:45 P. M Rita Margaret Restivo Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Ye 1 - M 2 - F Months Days Min. Year) 1923 Hours 202-12-8685 87 Director Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director notified 1 Yes 2 X No MD Baltimore Catonsville ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 232 RGT 719 Maiden Choice Lane 21228 USA 11. Marital Status Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White "natural" Specify 3 X Widowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Singer Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ John Schaffer Walburga Demharter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health or other <u>Susan Gibson Daughter</u> Baroness Court; Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Department of F Important: If ite any injury or ot once. Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) John's Cemetery 6/8/2011 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. of Funeral Service Li 630 Edmondson Avenue: Catonsville Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the di Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CEREBROVASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2 X No After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. death. Accident Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one)

2

RITA RESTIVO

2011

State Registrar 29b. Signature and title

JACKIE JONES,

IIIN 0 9 201

CRNP

on who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

2011

VOID
CERTIFICATE 88

2011-18323

SEE

CERTIFICATE 88

2011-25006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 5, Helen J. Seabrease 2011 4:40 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Frederick Villa Nursing Home Catonsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 M 2 XF Hours Maryland 1173071934 Director 218-30-6919 76 Usual Residence of Decedent 28a-f show 10a, State 10h. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland **Funeral Director** 1 Yes 2 X No MD Baltimore Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 21228 404 Shadvnook Avenue filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates. Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Mail Clerk State Government 0 10 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Department of Health and Menta Important: If Item 27 is marked any injury or other traumations ၉ Helen Clardy Clarence Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Shadynook Avenue, Baltimore, Maryland 21228 Seabrease / Dau. M. Darlene Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/8/2011 Baltimore, Maryland New Cathedral Ceme. 4 Donation 5 Other (Specify) nuturi of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Immediate Cause (Final Onset and Death Physician/ Meny disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): ding physician Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day Month Year signed by the at d be detached fo 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law r 24 hours after death.
 Funeral Director: After this certificate has b autopsy performed? 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 6, D36942 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rederick Rd. Certerynilli, mp 21228 1009 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ay 22, Physician/ 2011 May 10:45 AM Clarence Philip Small Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring 9. Birthplace (State or Foreign Country|Republic of Panama Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days Hours (Month, Day, Yea 1 🛛 M 2 🗆 F 1920 90 Director 577-76-9355 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1613 Billman Lane 20902 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ⊠ Yes 2 □ No Specify Panamanian Specify: West Indian 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Panama Navy Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mariana Maude Plummer Gillings Small Ihiberto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1613 Billman Ln., Silver Spring, MD 20902 Norma Small Warren (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State D6-04-2011 Pinelawn Cemetery Pinelawn, NY 4 ☐ Conation 5 ☐ Other (Specify) Signature of Funeral Service License <sup>2</sup> Name and Address of Facility Caribbean Funeral Service NY 11419 130-02 Liberty Ave., Richmond Hill, Part 1. Enter the disease, or complications that caused use shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine as a consequence of): neumonia To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗓 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific 5,22,11 D66372

Registrar

DHMH 17 Rev 7/2009

1500 Forest Glen Rd., Silver Spring, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Majid Rahmanianshahri, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Derek Jeremiah Snead State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 27, 2011 0217 hrs **Medical Examiner** Derek Jerymiah Snead 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** West Virginia Foreign Country) Months 8 Days Hours Director Sept. 08, 2009 236-55-1609 1 1 X M 2\_\_\_F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 1 Yes 2 X No WV Marion Fairmont . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygene, and the matter of Health and Montal Hygene, for a "natural", or items 23a or 28a-f sho or other transmitic event, the Modical Examiner must be notified at once rector 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 26554 U.S.A. 480 Leonard Ave. Ext. Apt 6D 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Yes Specify: Black f Yes, Give Year 1 Yes 2 X No specify. 3 Widowed 4 Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " Itimore, MD 21215-0036 Compl N/A 0 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Snead Blaire A. Davison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blaire A. Davison - Mother 480 Leonard Ave. Ext. Apt 6D, Fairmont, WV 26554 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
Evergreen
Cemetery 1 X Burial 2 Cremation 3 Removal from State 6-4-2011 Fairmont, WV 4 Donation 5 Other Specify 22 Name and Address of Facility Frey Home for Funerals, Inc 320 Madison St., Fairmont, 21. Sign three of Funeral Service Licenses 🖭 🗗 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failule. List only one cause on each line /Medical Death Sudden Unexplained Death In Childhood Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and 뗭 23a,27,28a-f per me g920 10-5-11 vt X UNPENDED AMENDED tending physician use as the burial Physician/Medi Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 互 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? . death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Division of Vital 盎 Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 5 Pending 1 Yes 2 X No after death. the fd 5-27-11 fd 1:15am unknown 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 Suicide 6 X Could not be or Town, State) (Specify) Homicide found in\_house Avalon Ave. Hagerstown, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 27, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day 9 32. Registrar's Sgnature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KALTIMOR If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 - M 2 XF Months Hours Min. Country) **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified of once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director BAITIMORE 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 
Never Married 2 
Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Specify: BLACK Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) conday (0-12) College (1-4 or 5+) DOMESTIC SEKEEPER Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ပ DNE ICEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVEHTER Rd Balto, 20a. Method of Disposition 20b. Place of Disposition (Name of Surial 2 Cremation 3 Removal from State Cemetery, crematory or other GWYNNS CHAPEL PELHAM, NC 151 CHAPEL CEMERIC 4 Donation 5 Other (Specify) GREENE FUNERAL SCUS 21. Signatu du Fune ervi e Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence or, ohysician and the burial-transit that the death certificate be executed WD resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant a
9 Unknown Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ils certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires within 24 hours after death.

Yo the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 XNO Other: 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 1 Natural 5 Pending injury Accident Investigation 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practice on: To the best of my knowledge, doct occurred at the time date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
Thurk 8/h 201) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 LOCK LOWER BIVE: 13 32. Re strar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** 20 AM Smith Herbert George d011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner + 1 Square more Franklin 05 If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Min. 1 ₹ M 2 ☐ F Months Days Hours 89 229 18 9020 09/24/1921 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Ite Marical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21220 Walkway Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: Specify: à Specify: white 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Assembler Areo-Space 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental H Be Mary Mabel Norcross John Will Smith မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .. Pages 1 and the ment of Health a 504 Crisfield Road Middle River Maryland 21220 Phyllis M. Howell (daughter) Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Baltimore County, Md. Gardens of Faith Cem. 6/9/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign Jure of Funeral Servi Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician a. Kes pica + cosequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner executed burial-tran and Due to (or as a consequence of): physician Box 68760 law requires that the death certificate be Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 Other (specify) signed by the a d be detached for P. 0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No ¹□Yes 2 No 1 Nyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06/06/2011 Zhang, MD D70605 Yuling 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD Date filed (Month, Pay, Year) Chang 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ZZ AM Laura G. Schwind 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimor Baltimore trathmore Ave If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Davs Hours Min. October 25 218-01-9991 Maryland 1918 Director Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director Baltimore Maryland N/A 1 XYes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral USA 21213 2204 Kentucky Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname)

Josephine D'Amore 17. Father's Name (First, Middle, Last) ٥ Santo Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Kentucky Avenue Baltimore Maryland 21213 Rev. Thomas Schwind/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Gardens of Faith Cemetery Baltimore Maryland 6/10/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard Jordan Linc 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licer 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death the cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director; After this certificate 2 🗌 No Yes 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Baltimore 32. Reg State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Lucille M. Staiger May 4:00 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 □ M 2 😾 F Oct 3 1929 Minnesota Director 81 474-28-0228 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked by the than "natural", or items 23a or 28a-f sho is marked event, the Medical Examiner must be notified at raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🌠 No Owings Mills MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21117 58A Lower Gate Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: white If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4\_or 5+) financial accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Blanche Irene Taylor John Bernard Staiger traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a :: If item 27 is 3501 Cemetary Circle Knoxville, MD Rick Staiger/nephew other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) injury or Department of Important: If any injury or once. 4 ▼ Donation 5 Other (Specify) Signature of Funeral Service Licepese Ronald S Ward Wirector, State and Address of Facility and 655 W. Baltimore Street Baltimore, MD 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thick, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Chromic obstructive line disease disease or condition resulting in death) 1.eavs Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to jor as a consequence of j if any leading to immedicause. Enter Underlying ng physician and as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months: Day Pregnant at time of death Month Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Division of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) (10 8p2 C P 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of il or Attending F safter death. I Director: After 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practic negro the cause of my income and the course of the cause (Check To the I within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 00070635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel 6701 N Charbes ST Suite 4105 31. Date filed (Month, Day, Year) 32. garar's Signature Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 25, Physician/ 2011 1:00 AM M Mary D. Saunders Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crofton Crofton Convalescent Center Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Month Day, Yea Months Days Hours Min. 1 □ M 2 🔯 Mar 1922 Washington DC Director 89 579**-**18-5531 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 1 Yes 2 X No Prince George's Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20715 USA 7500 Laurel Bowie Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 💢 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) bookkeeper 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pompea Lizzi Santi DiCenzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 251 Concerto Avenue Centreville, MD Robert H. Butler/friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ٥ injury 4 X Donation 5 Other (Specify) Signalius of Funeral Service Licensee 23 Name and Address of Facility Board 655 W. Baltimore Street Wirector MD Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease of condition Priysician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ξ Vear Month Pregnant at time of death 5 Other (specify) hed 9 Unknown g Unknown Division of Vital Records, P.O. signed by t. Id be detach: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has ; page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 \( \text{Yes} 5 Pending 2  $\square$  No 24 hours after death Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) A MD 14300 GALLANT FOX LANE #1222 BOWIE MD20715 Name and address of person who compl Registrar's Signat State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Physician May 26, 9:17 AMM Anne N. Silcox /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Kent Kennedyville 28318 Comegys Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** 1 □ M 2 🛱 F New Hampshire May 21, 1924 87 Director 218**–**20–6431 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everning reast Lear ciffical 10c. City, Town or Location 10b. County 1 ☐ Yes 2√ No Director Kennedyville MD Kent 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21645 28318 Comegys Road Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorced un Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Warrin Hugh McCulloh Branham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28230 Comegys Road Kennedyville, MD John Silcox/son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) State and Address of Facility Board 655 W. Baltimore Street 21. Signature of Funeral Service Licenses 21201 Baltimore, MD 10 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mole of dying, such is cardiac or respiratory arrest, shock or heart failure. List only one cause are each line. Immediate Quse (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Yes 2 0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform No 2/ 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1	Plea am   = State   = Registrar	nse Type or F end items em 21 per	Print in Black 20a-c 22 pe Mary 916,067 Sa, 8916,067	Indelible II T fh g91 09/261181 ertificate of	n <b>k. Ensure</b> 5 6 20 11 Bealth and Death	All Copie Mental Hy	rgiene Reg. No 20	gible.	8333_		
	Physicia	n/	1. Decedent's Name (First, Middle Miche			2. Date of Death  Month  Day  Year  10:/6							
	Medic Examin		4a. Facility Name (if not institution,  Doctors Hosp		er)	4b. City, Town,	or Location of Dea	ath	4c. Count <b>Prin</b>	ty of Death ace Georg	George's		
	Funeral Director		5. Social Security Number 579–92–0212	6. Sex 1 □ M 2 <b>X</b> F	Age (In yrs. last birthda) 43 Yrs.	/) If Under 1 Year Months Day			71968	9. Birthplace (State or Country) Washington			
) yland	-f show ed at	h	Usual Residence of Decedent  10a. State  10b. County  Prince						side City Limits				
th the Ma	3a or 28a t be notif	ral Director	10e. Street and Number	el Drive		10f. Zip Code	20708		10g. Citizen of <b>USA</b>	f What Country?			
036 s after death wi	Department of Health and Mental Hygiene. Important: If item 273a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	11. Marital Status  1 Never Married 2 X Mar  3 Widowed 4 Divorced	12. Was Deceder Armed Force 1  Yes 2	es? La No	3. Was Decedent of If Yes, specify Cu	f Hispanic Origin? ( uban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
Maryland 21215-0036 sound be filed within 72 hours after	iene. r than "natur the Medical	Completed by		nt's Education est grade completed) College (1-4	(Gi	cedent's Usual Occ ve kind of work dor . DO NOT use retire ousewife	ne during most of w	orking	16b. Kind of Business Industry  own home				
land 2	ental Hygi rked othe ic event, i	l oo b	17. Father's Name (First, Middle, L				18. Mother's N	ame (First, Middle rice Sam	all	me)			
Mary 12 should	alth and M 27 is mar r traumat		19a. Informant's Name/Relations  Daniel Johnson		Rural Route Numb	Route Number, City or Town, State, Zip Code)							
Baltimore,	ent of Hex nt: If item ry or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (6	3 Removal from S		sposition (Name of rematory or other p	olace) 6-	Date -15-11		rf. Md.			
Baltil Permit. F	Departm Importa any inju		21. Signature of Funeral Service I  Ronald S. I		ctor, per	22. Name and Add 1661 . Good Baltimore	ress of Facility R	obert G. tate Ana timote,	MASOR MASOR	orf, Md. Tunerals D. Dc. 20	1000E+ 0020		
	ysician/ Medical xaminer		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each	used the death. Do not	enter the mode of o	lying, such as cardi	ac or respiratory a	C En_	Appro Interv	oximate val Between et and Death		
<b>60</b> ate be executed	physician and the buri <b>al</b> -transit	Sequentially list conditions, far my, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
Box 68760 edeath certificate be	been signed by the attending physicia should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	1 🗌 Live B		3			1 "	Date of delivery Month Day			
ls, P.O.	n signed by Ild be detacl	[출	Part II. Other significant conditi	ions contributing to de	ath but not resulting in th	ne underlying cause	e given in Part I.		tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown				
Record The law requ	2 33	Completed						per	is an 24b topsy formed?	b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No			
'ital	certifi	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	patient 2 ☐ ER/Outpa	_ 1	Other:	heck only one)	aidanaa 6 🗆 O	ther (Specify)			
of V	erthis eraldi	e: 10	27. Manner of Death	28a. Date o		e of 28c. In	njury at		how injury occu				
Division of Vital Records, P.O. I	within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	1	igation 1 not be 28e. Place of	of Injury - At home, farm, g, etc. (Specify)	M 1	☐ Yes 2 ☐ No		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Te Hospitz	in 24 hour. h <b>e Funera</b> pleted fille	Medical	(Chook 2 Modical	Evaminer: On the basis	st of my knowledge, dea s of examination and/or in the best of my knowled	vestigation, in my o	ninion, death occurr	ed at the time. date	e and place, and c	due to the cause(s)	and manner stated		
٩	vithin 2 To the I		29b. Signature and title of certifie	- July	WV		S 6 2	ho	29d. Date sign	aned (Month) Day, You	ear)		
	2)			who completed cause	of death (Item 23a) (Typ		Rond,	LANHAM	, MD	20706			
	Sta Registr		31. Date filed (Month, Day, Year)		gistrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2:25 PM Smith 2011 June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 13711 Princess Anne Way Phoenix 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Pennsylvania (Month, Day, Year) February 27 Days Hours Min. 1 □ M 2 🛛 F 1946 65 212-48-5479 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Baltimore Phoenix 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò Funeral items 23a 21131 13711 Princess Anne Way United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 14. Race - American Indian Black, White, etc. 5 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give ð Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: white "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) education secretary permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Hinkle Luther Dean Zweier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philadelphia, PA 19146 615 S. Banbrev St. Dean McCord Smith/son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory June 9,2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown CONCRE 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2: 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation the 24 hours ar er dear 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29d. Date signed (Month, Day, Year) 29c. License number 20051921 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St FPE 203 Gordon 6565 7 31. Date filed (Month, Day, Year) . Registrar's Signat State Registrar

11-04026 Lois Jean Smythe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Reg. No.    A   Decedent's Name (First, Middle,Last)									
P fedical	hysicia Exami	ner	Lois Jean Smythe May 29, 2011									
			4a. Facility Name (if not institution, give street and number) 4300 block Windsor Mill Road	4b. City, Town, or Location of Dea Baltimore	th	4c. County of Death Baltim						
	ineral rector		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	if Under 1 Year If Under 24H Months Days Hours Mi		/ 1 9 7 0 Foreig						
	any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d.									
and	<b>8</b>	5	MD Anne Arundel Linthicum									
e Maryl	23a nr 28a-f sho notified at once,	Director	10e. Street and Number 415 West Maple Road	10f. Zip Code 21090	10	og. Citizen of What Coul USA	ntry?					
with th	ns 23a be notif		11 Marital Status 12 Was Decedent Ever in U.S. 13 \	Vas Decedent of Hispanic Origin? (		14. Race - Ameri	can Indian, Black,					
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland	al", nr items	by Funeral	1 Yes 2 No	f Yes, specify Cuban, Mexican, Puer Yes 2 No specify:	to Rican, etc.)	White, etc. White Specify:						
hours	*natur			ent's Usual Occupation (Give kind of most of working life, DO NOT use re		16b. Kind of Business/	ndustry					
<b>036</b> ithin 72	Hygiene. I other than "natur the Medical Exami	ompleted		ance Director		Health						
<b>21215-0036</b> ald be filed within 7	Hygie ed othe	Ü	17. Father's Name (First, Middle, Last)		ne (First, Middle, M : Wells	Maiden Surname)						
212 ould be	is marked tic event,	To Be		ing Address (Street and Number or	Rural Route Num							
MD and 2 sho	of Health and If item 27 is her traumation			Central Ave Consistion (Name of cemetery,	Date Bui	nie MD 2						
Baltimore, permit. Pages 1 at	Department of Health and Mental Important: If item 27 is marked injury ar other traumatic event,		1 Burial 2 Cremation 3 Removal from State Atlanti 4 Donation 5 Other Specify:	other place) C Crem 06	5/01/11							
Balti ermit.	Departm Imports njury n	Ì	21. Signature of Funeral Service Licensee 22	. Name and Address of Facility Sj	_	_						
	sician	+	23a. Fart I. Enter the disease, or complications that caused the death. Do not enter	homasAllenPA 7 r the mode of dying, such as cardiac			Approximate Interval Between Onset and					
	edical miner	1	Immediate Cause (Final disease a. Gunshot Wound of Head									
			or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
		Examiner	if any, leading to immediate  Cause. Enter Underlying Cause  (Disease or injury that initiated									
uted	id ransit		events resulting in death) Last  Due to (or as a consequence of):  d.									
8760, ficate be executed	physician and the burial - transit	n/Medical	UNPENDED AMENDED									
	g sg		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregi	nancy	23d. Date of delivery	/ Day Year					
of Vital Records, P.O. Box 6	the attending properties that	Physicia	Decement at time of death	Other (Specify)		Į.						
P.O. E	ned by th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		bacco use contribute to						
ds, F	een signe				- 24a. Was a	an   24b. Were au	topsy findings available					
of Vital Records,	te has b	ompleted			autops perfor	med? death?	completion of cause of					
Z = =	his certificate director, page	ပ	25. Was case referred to medical	26.Place of Death (Chec	- C							
Vita bysicis	this ce	e Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other Nurs	ing Home 5	Residence 6 🗸 Other	: Scene					
	~ 2	ertification:	27. Manner of Death  1 Natural 5 Pending PoUND: 2 Accident Investigation  28a. Date of Injury FOWDID: Day, Year) FOUND: May 29, 2011 28b. Time of FOUND: FOUND: 1830 hrs	of Injury 28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe h Subject shot	now injury occurred						
Division tal or Attendi	iours after d seral Direct filled in by	Tiff	3 Suicide 6 Could not be determined			treet and Number or Ru tate) indsor Mill Road, Balt						
DiV To the Hospital or	within 24 hours after death.  To the Funeral Director: completely filled in by the	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc	curred at the time, date and place, ar	nd due to the cause	e(s) and manner as state	ed.					
To th	withir To th compl	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month										
			Patri an- Polles	O.C.M.E.		May 30, 2011	, = =y, / 000/					
			Name and address of person who completed cause of death (Item 23a)     Patricia Aronica-Pollak MD.	900 W. Baltimore Street,	Baltimore, MI	D 21223						
	S: Regis	tate trar	31. Date filed Month, Day Year 1 32. Registrar's Signature	W.								
		_										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 7:02 PM YN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner SAVAGE HOWARD WOODWARD STREET If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Yea Min. Country) 1 🗆 M 2 🔀 F N.J144-18-5362 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No SEVERN MDANNE ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò Funeral 5, U. items 23a INNKEEPER DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. Hygiene. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) INSURANCE OFFICE should be filed with and Mental Hygien. 3 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မှ MCKAY DOLORES RAY ALFRED t. Page 1 and 2 should be to the total to the total the total the total the total the total to the total the total 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PAYGHTER KEETON ROAD ELKRIDGE MD. 21075 8032 MELISSA D. SKAGGS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State ARDENT CREMATION JUNE 9.2011 HANOVER MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility MARZYLLD FUNERAL CHAPEL ervice Li ensee JOSEPH L. CANBY 6009 HARFORD ROAD BALTIMORE MD 21214 M 000 78 23a. P . Enter the disease or complications that caused hour, or heart failure of ist only one cause on each line r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Inset and Death I ediate Cause (Final Physician/ diseas or condition or resulting in death) Medical Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of death? 1 Yes 2 No 1 ( E / S 2 4 within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medica examiner? the funeral director, To Be Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Tyes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 28c. Injury at injury Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29d. Date signed (Month, 29b. Signatur me and address of person who completed cause of death (Item 23a) (Type, Print) State JUN 0 9 2011 Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 32. Registrar's Signature

ORIGINAL

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per FH G916 6/09/2011 JH State of Maryland / Department of Health and Mental Hygiene amend #11 Per FH G916 6/14/2011 Department of Health and Mental Hygiene C916 6/14/2014 Hall Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day 9:06 A M Towns 2011 **Physician** une /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) . Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F Maryland 214-30-7386 Apr 19, 1934 77 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 1X Yes 2 □ No Baltimore Baltimore Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f, Zip-Code ò ral", or items 23a o Examiner must be U.S.A 21207 2121 Windsor Garden Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 X
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Black ģ **3** Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Our Lady of Lord Church College (1-4 or 5+) other than Bookkeeper event, the 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora Reeder Jessie Reeder is marked ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau once. 4748 Old Court Road Baltimore, Maryland 21208 Kimberly Johnson 20c. Location - City or Town, State Catonsville, MD Owings Wills, Md. 20b. Place of Disposition (Name of 20a Method of Disposition Metro Crematory place) +XIBurial XXCremation 3 ☐ Removal from State 06/13/11 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Si u ature of Fineral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217

23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmontry disease or condition resulting in death) Due to (or as a conseque ce of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mha Examiner Due to for as a nonsequence of The law requires that the death certificate be executed bluih Massine attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy Year Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ Yes 2 No has page 2 🗌 No 1 Yes certificate Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 FR/Outpatient 3 🗀 DOA မ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 2 No Μ 1 Tyes 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 4,2011 ucRes - 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Greenberr MD sei Ko 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5,10f&19b Per ANA G916 6/09/2011 JH
State of Maryland Department of Health and Mental Hygiene
amend #1 Per Phy G916 6/24/2011 JH
amend #19a Per ANA BD G916 Certificate of Death 6/29/2011 JH
amend #19a Per ANA BD G916 - State
Registrar amend #19a Per ANA BD G916 Certificate of Death 6/1

1. Decedent's Name (First, Middle, Last) Abraham Herbert Trock AKA Herbert 2. Date of Death 3. Time of Death Year Physician/ Trock Abraham Trock brotham-May 24 2:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown <u>Seasons Hospice/Northwest Hospital</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Security Number 3320 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 0V 15, 1929 New York 1 😾 M 2 □ F Months Director Nov Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Randallstown Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA by Funeral 3713 Cassen Road 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. ↑ Wever Married XX Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 💢 No Specify If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates unk 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+)
5+ Elementary/Seconday (0-12) engineer h and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edith Cohen Leo Trock 19a. Informant's Name/Relationship (*Type, Print*) **Helena** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Pip Gorde) 3713 Cassen Road Randallstown, MD 2113B Helen F. Trock/spouse fitem 2 r other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Serv State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore. MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure./List only one cause on each line. Approximate nterval Between ENd Stage (ardiom Jopula Immediate-Cause (Final -Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the k IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
g ☐ Unknown jo Day Month Pregnant at time of death detached Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? 2 No 1 🗌 Yes 2 🗆 No Yes 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation by the 24 hours after deat Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) USKNapalneM.D. D0057-465 5125111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7.709

7.709 31. Date filed (Month, Day, Year) JUN 0 9 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04083 State of Maryland / Department of Health and Mental Hygiene Charles Windsor Tate 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 31, 2011 2315 hrs Medical Examiner Charles Windsor Tate

4a. Facility Name (if not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Prince George's W/B Rt. 198 just east of RT. 197 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. 5. Social Security Number If Under 1 Year **Funeral** <sup>Coreign</sup> North Caro<u>lin</u>a Min. Hours Months Davs Director Feb 10, 1937 246-46-8582 1X M 2 F 74 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 1 Yes 2 No tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. Itimore, MD 21215-0036

iit. Pages I and 2 should be filed within 72 hours after death with the Maryland arturnet of Health and Mental Hygiene.

arturnet of Health and Mental Hygiene.

"the marked other than "tantural", or items 23a or 28a-f sho ry or other tranmatic event, the Medical Examiner must be notified at once. Prince George Laure1 Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20707 107 Irving Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2X No Yes 1 Yes 2 X No specify: If Yes, Give Year or Dates: white Specify: 3 X Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US postal system mail carrier 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley Barrett Be William Irving Tate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) ဥ 107 Irving Street laurel, MD Charles D. Tate/son 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Bunal 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Lig Ronald ade, Director art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, 23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown <u>6</u> Completed 24b. Were autopsy findings available page 2 should 24a. Was an has been prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene DOA ER/Outpatient 3 this 1 Yes ဥ 28c, Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Certification: Pedestrian struck by auto May 31, 2011 Natural 1 Yes 2 ✔ No Division 5 Pending Director: 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) W/B Rt. 198 just east of Rt. 197, Laurel, MD within 24 no...

To the Funeral Diampletely filled determined (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29) Signature and title of certifier June 1, 2011 O.C.M.E. 0 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month) Registrar's Signa State Registrar

DHMH 17 Rev 1/2001 OCME 2006

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Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland to 7 Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	1	19a. Informant's Name/Relat				1	-				Route Numb	-			Code)		
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and the	Physician/		Immediate Cause (Final disease or condition	ist offig of			rebro	vasc	ulai	r acc	cide	nit			/	Interval E Onset an		
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Division of Vital Records,	ding Phys :h. After this of funeral dir		27. Manner of Death  1 Natural 5 Pe	nding	28a. Date of inju (Month, Da	iry	28b. Time of injury	28	Bc. Injury work	at ?	2	28d. Describe				/		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WOLFERMAN Physician/ 0646 AM JANET JUN 201 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLADO MEDICAL COOTER If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Hours Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland notified at Director 1 Ses 2 □ No 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be r Funeral more items Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner Armed Forces Black, White, etc. ö 1 Never Married 2 Married ğ Yes 2 🔍 📈 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes. Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Management Inama Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ပ 190Ur 21047 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lachos <u>onn</u>a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Temation 3 Removal from State tomore 4 Donation 5 Other (Specify) uneral Service Live 22. Name and Address of Facility Home altimore 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final SOFT TISSUE INFECTION Physician NECROTIZING disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DIABETES MELLITUS Gequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 🔀 No Year Month Day Pregnant at time of death been signed by the s should be detached t g Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 No Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Hospital 2 🗆 No ၉ 1 X Yes 1 🗷 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the ful 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, WD P25607 JUN 02 2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 22 GREENE ST. mo 21201 BILGE KALYON 31. Date filed (Month, Day, JUN 0 9 2011 egistrar' Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 20 pM rendo 6 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLin Square Hospital Baltimore Roseda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 229-74-4750 1 □ M 2 1 E Months Days Hours Min. Country) Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Medical Evan, that the inclinited at Yes 2 No Director aure Street and Numbe 10g. Citizen of What Country? 10f. Zip Code with WOOK 20723 Monor Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 No Specify. Completed by Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. QO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) eide 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental His marked otl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Harbor 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If ite any Injury or o 1 Burial 2 ☐ Cremation 3 Bemoval from State 4☐Donation Menorial 10/2011 5 ☐ Other (Spega Funeral Service 22. Name and Address of Facility 23a. Part 1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Bilaterah disease or condition resulting in death) Pheumonia /Medical Due to (or as a consequence of): Examiner Lung metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burital-transit completely filled in by the funeral director, page 2 should be detached for use as the burital-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 3 Probably 4 → Onknown 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D00647TT 06 04 2011 CASILIADES MD. 00. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BaLTO 21237 FRANKLIN SQUARE DR md vasiliades Minus 9000 31. Date filed (Month, Day, Year, 32. Registrar's Signature State JUN 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:35 AM Medical JUNE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SON SEC BALTI MORE OURS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 X M 2 🗆 F 215-84-8432 50 Min. Director MD 22-1960 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. Completed by Funeral Director be notified at 10d. Inside City Limits Baltimore MD 1 ▼ Yes 2 □ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 W. Mulberry Street 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Hygiene. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 💢 No Specify: Specify: Black 3 Widowed 4 Divorced 27 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Company Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas C. Whitehead Annie Bell Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Forehand Health tem 27 2810 W. Mulberry St. Balto. MD 21223 UKN Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crem. Hanover MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Phillip A Weatherford FS PA 2431 E Oliver ST Balto. MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition **Medical** resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No be detached for Pregnant at time of death 5 Other (specify) Month Day Year g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Honknown iis certificate has been si director, page 2 should . Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director: After this certificate has! performed Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 2 H/0 1 Impatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manne Teath 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes □ Accident Investigation 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 30. Name and address of person who completed gause of death (trem 23a) (Type, Print SECOUR State 9 Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

State Registrar 32. Regist ir's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:09 A Physician/ Month Year **Lenwood Earl Wilson** PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL AGNES pritimere N/A Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 F (Month, Day, Year) Sep 11, 1937 Months Days Hours Director North Carolina 264-44-4853 Usual Residence of Decedent show 10a. State 10b. County : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 ☐ Yes 2 ☐ No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A 21230 3017 Stranden Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 Yes : 1955 1 ☐ Yes 2 🗷 No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates 1957 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **US Merchant Marines** Merchant Seaman permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Louise Wilson Porter George McCloud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3017 Stranden Road Baltimore, Maryland 21230 Cora Wilson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Da Burial 2 Cremation 3 Removal from State 06/13/11 Owings Mills, Md. 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Due to (or as a consequence of): -xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 COPD Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen PHERMOTHORAX 24b. Were autopsy findings available 24a. Was an has prior to completion of death? performed? Lung CANCER certificate 2 No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Monpatient 2 ER/Outpatient 3 DOA Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the basis of my linuxed up death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1240 W3 MEDICAL KESTABAT JUNE 3 20 (1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMONE MD 21229 9:0 3 CATON MSALOS 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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		-	For State Registrar	Otate of Iviary		tificate of L			leg. No.	10347			
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Ma	and 2 sho Health and tem 27 is r		19a. Informant's Name/Relationship (T) Trevor Bludis/so						Number, City or Town, State, Zip Code) erstown, MD 21136				
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of aatory or other plac		Date	20c. Location - City	or Town, State			
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			MA 10	the mo			70635		612111				
			30. Name and address of person who o				Suite	405 8	Bulhmon	e, des 21204.			
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Physiciar Medica	1/		Marv		liams				J <sup>Month</sup> June	06	, 2011	3:57P м	
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	3924 Cranston Avenue  5. Social Security Number 6. Sex 7. Age (In yrs. )						If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	th	9. Birthplace (State or For		
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ter o	হ	<ul><li>11. Marital Status</li><li>1 ☐ Never Marrie</li><li>3 Widowed 4</li></ul>		12. Was Deceden Armed Forces 1  Yes 2 If Yes, Give Year or Dates	? <b>X</b> No		Was Decedent of H f Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)			ican Indian, , etc. African erican	
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Baltimore, permit. Page 1 and Department of He Important: If item any injury or othe once.		4 Donation	Cremation 3 5 Other (Specif	fy)		emetery, crei	osition (Name of matory or other place Semetery	7 0	Date 6-11-11	W		ton, NC	
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  The The Fundal Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Bir 4 Pregname 9 Unknown	th 2 ☐ Feta nt at time of c	Ideath 3	Ectopic pregnan Other (specify)	су			23d. Date of del Month	livery Day Year	
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1		30. Name and addr	BM.II	ex 91	00 Ca	iton	ave	BALT	mone	$\cap$	W) 2	1229	
Sta Registra		31. Date filed (Mont		Server 32. Heg	istrar's 7 gna	face							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 1241 PM 20 i /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** trospital ambridge Beneral Dorchester Dorchester 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 1 M 2 □ F 212-81 Director 00010 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mental Examiner of the Examiner of the contract of the con 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WH 1 ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surgame, 17. Father's Name (First, Middle, Last) Be NOH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a someoguenes of) or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Division of Vital Records, P.O. 9 Hinknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 🗌 Yes 2 🗌 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate | 2 🗆 No 6 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Tyes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed State

DHMH 17 Rev 1/2001

Registrar

AS5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 20°11 Clarence James Bell 17:30P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
07-31-1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 578-52-12576 1 🔀 M 2 🗆 F 86 Yrs. Virginia Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f DC Washington, D. C. 1 XYes 2 No 10e, Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? must be Funeral 23a 20001 USA 1928 2nd Street, N.W. items ural", or iterr I Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1943 1 X Yes 2 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: to Specify: Black Completed 3 Widowed 4 Divorced 46 9 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Industry Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Florence Broadus Robert Bell 19a. Informant's Name/Relationship (Type, Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4971 Derryfield Court Waldorf, Maryland 20602 Arvette Leake-Davis 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Harmony Mem. Pk. 06 - 01 - 2011Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Ramon Amidians, II Funeral Service P.A. 5202 PrincetonsDelightDr., Bowie, MD 20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transi Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō 5 Other (specify) Month Day Year signed by the at the detached for The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 X No the Hospital or Attending Physician: The thin 24 hours after death.

the Funeral Director: After this certificate I 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dorothy Christine Bunker May 2011 9:16  $A^{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline 25400 Calvert Drive Greensboro . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) 8 Date of Birth Funeral 1 - M 2 1 F Month, Day, Maryland Director 214-38-1413 90 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norffied as once. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21639 25400 Calvert Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Susie Pearl Ford Robert Leroy Fogwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greensboro, Maryland 21639 25400 Calvert Drive Susan Bunker/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Dover, Delaware May 27, 2011 Capitol Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. of Funeral Service Licens 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a conseque ice of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death certificate has been signed by the rector, page 2 should be detached a 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 욘 5 Residence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William Wilson Blades 2011 15 6:10 A May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Denton Caroline Home for Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**7** M 2 □ F Months Hours Yrs August 14, 1926 220-34-9409 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ANo Director Denton Caroline Maryland 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21629 Funeral 9183 New Bridge Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ∐Yes 2 ∏ If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No ğ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) US Post Office/ Elementary/Secondary (0-12) College (1-4or 5+) Food Production Rural Letter Carrier/Farming 11 H.S. Grad. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Mae Jump Rolen James Blades မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9183 New Bridge Road Denton, Maryland Doris B. Blades/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State May 22, 2011 Denton, Maryland Denton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Lice 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, Maryland 21629 12 South Second Street Approximate Interval Between On et and Death 23a. Part 1. Ef ter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions Physician/Medical Examiner fran, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1∐Yes 2∭ No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wafik I.Zaki, M.D. 920 Market Street Denton, Maryland 21629

Registrar

State

31. Date filed (Month

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Division of Vital Records,

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5/19/2011 7:29 A Lorraine E. Bailey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12806 Whisper Trace Dr. Worcester Ocean City Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign  $\mathbf{C}\hat{\mathbf{K}}^{\text{ountry}}$ ) **Funeral** 1 □ M 2 🏝 F Days Min. 9/29/1925ar 85 Director 369-26**-**6944 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Ocean City Worcester 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12806 Whisper Trace Dr. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2\$ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Angelo Mollika Myrta Fenich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Bailey 122806 Whisper Trace Dr. Ocean City, MD 21842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State First State Crematory 5/19/2011 4 Donation 5 Other (Specify) Millsboro, DE 21. Signature of 22. Name and Address of Facility The Burbage Funeral Home vice Licensee 108 William St. , Berlin, MD 21811 23a. Part 1 Enter the disease, or complicate shoot, or heart failure. List only one ca disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ enal disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** PONTENSC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Examir physician and the burial-transit that the death certificate be executed TUPERLEPIDEMIN that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day signed by the a Id be detached f g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, has been sig ge 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending in 24 hours area was the Euneral Director. After a maleted filled in by the furnished 1 Yes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOS 24 OLD OLEM CIT

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04088 Jessica Irene Baker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 0200 hrs Baker Irene **Medical Examiner** Jessica June 1, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett 6th Street near Railroad Tracks If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Country)MD Months Days Hours Director Jul 11, 1992 215-67-6225 1 M 2 XF 18 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location III 1 X Yes 2 No 28a-f show MD Garrett Oakland Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she
injury or other traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1176 Hutton Road 21550 uneral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Maritai Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces' 1 XNever Married 2 Married Yes 2 X No Specify: white ũ 3 Widowed 4 Divorced Give Year 1 Yes 2 X No specify: 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) school student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sharon Kav (Pike) Baker <u>Verl W. Baker.</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print ) 1176 Hutton Road Oakland MD 21550 Sharon Baker mother 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6/3/2011 MD Scarpelli Funeral Home, P.A <u>Cresaptown</u> Donation 5 Other Specify: 22. Name and Address of Facility 21 Signature of Funeral Service Licenses Scarpelli Funeral Home, PA 23a. Part / Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval **Physician** en Onset and failure. List only one cause on each line. /Medical Death a Multiple Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown for 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? Yes 2 No 2 No 1 Yes After this certific 26.Place of Death (Check only one) 25. Was case referred to medica Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: A Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury fication: Subject cut and stabbed FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural 1 Yes 2 ✔ No 5 Pending I Director: Jun 1, 2011 0205 hrs Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide or Town, State) 6th Street near Railroad Tracks, Oakland, Md. determined (Specify) Railroad Tracks 4 V Homicide

29a. Certifier 1

Signature and title of certifier

0 9 2011

Laron Locke MD.

29b

State Registra and manner stated

Assistant Medical Examiner

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

June 1, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ay 17, Physician/ 2011 09:45 AM May Minnie Anita Casey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Days Months Hours April Day 9 ear) 1933 <sup>c</sup>∀irginia Yrs. Director 227-42-3898 78 Usual Residence of Decedent 28a-f shov 10a, State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No Maryland Forestville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r with Funeral 5503 Marlboro Pike # 20747 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: African American 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12th Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dewey Minnis Mason Sr. Doretha Hounshell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry V. Sherrod - Daughter 5503 Marlboro Pike # T2Forestville, Md. 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland Veterans
Cemetery 1 X Burial 2 Cremation 3 Removal from State 2011 4 Donation 5 Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Funeral Service Licenses 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to br as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Exam s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires i 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate 2 🗌 No 1 Yes 25. Was case referred to medica examiner? in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No ည 1 Tes 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation after death Director: / 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours aft

To the Funeral Dis

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C/2 /2

State Registrar

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2011

ALEINE M. CHRISTOPHER

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_		Registrar  1. Decedent's Name (First, Middle, Last)			tilloate of D	Cati		2. Date of De	Reg. No ath	· <u>C U I</u>	1	3. Time of	Death
Physic	cian/ dical	Mary Aleine Christon	pher					Month	Day 2	5 20	11	073	7 M
Exam		4a. Facility Name (if not institution, give street NEMORIAL 1405			4b. City, Town, or I		f Death			County of De	ath		
Funer: Directo	_	1/1-20-2383	7. Age (In yrs. last 84	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da ebru. 1	th <i>y, Year)</i> <b>4,1</b> 9		Country	ce (State of Vania	
permit Fage 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	į	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Loc	cation						100	d. Inside Cit	y Limits
ILL Z. I.Z. I.Z. I.Z. I.Z. I.Z. I.Z. I.Z	Director	Maryland Talbot	Cordov	/a								1 X Yes	2 🗆 No
th the 3a or t be r					10f. Zip Code					izen of What (	Countr	y?	
ath w	Fineral	31672 Bishop Drive	Was Decedent Ever in U.S.	13. V	21625 Vas Decedent of His	panic Orio	in? (Spec	ifv Yes or No-	USA	14. Race - An	nericar	n Indian	
ter de or its	2	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No	1f	Yes, specify Cuban  Yes 2X No	, Mexican				Black, Wh	nite, etc.		
urs af tural"			If Yes, Give Year or Dates.				Specify: Wh	ite					
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and 2 shr Health ar tem 27 is		Jeff Christopher/sor	A.		Double F								50
of Hear fitem		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ Rem	20b. Plac	ce of Dispos	sition (Name of natory or other place			ate		ocation - City			70
Page 1 tment of tank: If it		4 Donation 5 Other (Specify)	IOVAL ITOTA GIALE	* .	o Cemeter	· .	y 29	, 2011	Gree	nsboro	, M	aryla	nd
permit. Departn Importa	ouce.	21. Signatury of Funeral Service Licensee	1	F1.	Name and Address eegle and O. Greens	He 1f	enbe	in Fun	eral	Home,	Ρ.	A., P	0 Box
_		23a. Part 1. Enter the disease, or complicat	ions that caused the death. I					,		39	1	Approximate	э
- Physician	n/	shock, or heart failure. List only one ca Immediate Cause (Final disease or condition	iuse on each line.	cyl	1 1Pm	`a						nterval Bety Onset and D	Death
Medic		resulting in death)	Due to (or as a consequen	ice of):	2,000	10					1/1	([, 000 ]	
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ecuted and -transit	Examiner	Cause (Disease riinjury											
			resulting in death) Last  Due to (or as a consequence of):										
A death.  Afterding Physician: The law requires that the death certificate be extending the certificate be extended.  After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial	ledical	d									+		
ath certifica attending p	cian/M	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnanc	у	1					23d. Date of c	deliven	/	
death ne atte ed for	Sicia	in the past 12 months?  1  Yes 2 XNo	1 ☐ Live Birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown		Other (specify)	/				Month	D	ay Y	'ear
that the dea ned by the a detached f	Physi			ing in the u	nderlying cause give	en in Part I		23e. Did to	obacco u	se contribute	to the	cause of de	eath?
v requires the speed should be a	yd b	COPI	$\supset$					1 🗆	Yes 2	<b>X</b> No 3□	Proba	bly 4□l	Jnknown
aw requas beer 2 shou	plete							24a. Was		24b. Were a	autops	y findings a	vailable
The la arte ha	Completed							auto perfo 1  Yes	ormed?	death'	? .	□ No	
Physician: this certific al director,	Be	25. Was case referred to medical examiner?	oital:			ce of Deat	h (Check	only one)					
a Phys er this eral di	<u>1</u> 2			3b. Time of	t 3 □ DOA   28c. Injury	4 ⊔ Nu at		ne 5 Residente 18d. Describe 1		Other (Sp.  occurred	ecify)_		
ending eath. or: Aftu	ficat	1º Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	M 1 □ Y	/es 2 🗌	No						
To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After it completed filled in by the funeral	l Certificate:		28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		2	8f. Location (\$ City or Tow		d Number or F	Rural R	oute Numb	er,
he Hospi in 24 hou he Funer pleted fill	Medical	29a. Certifier (Check conly one) 1 Certifying Physician 2 Medical Examiner: 3 Certifying Nurse Pr.	n: To the best of my knowled On the basis of examination a actioner: To the best of my kn	nd/or invest	igation, in my opinion	n, death oc	curred at t	he time, date a	and place,	, and due to th	e caus	e(s) and mar ed.	nner stated.
To t with To to		29b. Signature and title of certifier	7 SKi		29c. License		53	4	29d. Dat	te signed (Mor	oth, Da	y, Year)	
		30. Name and address of person who comp	,		,	yland	216	629					
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	e									
Regis		MAY 31 2011	D. H	Parke									

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ 2011 John Carson Camp III 12:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Ocean Pines 30 Crest Haven Dr If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 / 3 / 1 9 4 6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 🛛 M 2 🗆 F Hours Country) Director 055-40-9307 65 PA Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov at 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f shedical Examiner must be notified tX☐ Yes 2 ☐ No Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 21811 30 Crest Haven Dr 12. Was Decedent Ever in U.S. Armed Forces? 1 √ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 27 is marked or traumatic eve ည John C. Camp Jr. Mabel Leona Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is 30 Crest Haven Dr, Ocean Pines MD 21811 Dorie Camp/wife permit. Page 1 and 2 Department of Healt Important: If item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ŏ 4 Donation 5 Other (Specify) Woodlawn Mem Park Easton. MD Fundal Service Licensee 22. Name and Address of Facility 108 William St Burbage Funeral Home Berlin MD 21811 23a. Part 1. Enter the disease, or complications triat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Part 1, Enter the disease, or complete shock, or heart failure. List only one cause o Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No 1 Yes Completed phods peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy certificate has page 2 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DDA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) work' 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ၉ D63424 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad Road Berlin, MD 1110

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 May 11:05 Janice L. Crozier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard 5245 Open Window 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🄀 F Months Hours 11/12/1948 214-52-8369 62 Yrs Ohio Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits must be notified at death with the Maryland Director 1 Yes 2 X No MD Howard Columbia 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 21044 5245 Open Window United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ò þ 1 Never Married 2X Married Yes 2 No filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) Marketing Director Furniture event, 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of Department of Health and Menta Important: If item 27 is marked a any injury or other traumating ပ William Conklin Rose Talaska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel George Crozier-husband 5245 Open Window Columbia, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Ardent Cremation Svc. 5-24-2011 Hanover, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licenses MD 21043 4112 Old Columbia Pike Ellicott City 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ BREAST METASTATI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner lears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir nding physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached for Unknown b Hospital or Attending Physician: The law requires that the c24 hours after death.
b Hours after death.
c Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🔀 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ71600 May 20, 2011 1 nd

Registrar

State

12

parke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TEJASWI SASTRY, 10710 Charter Drive, buile Gozo, Columbia, MD 21044

Registrar's Signature

11-03699 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Joshua Carroll State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 17, 2011 0216 hrs Medical Examiner Joshua Jamar Carroll 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 610 Modoc Lane Forest Heights Prince George's 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Foreign Country) DC Months Davs Hours Director 579 13 1200 6/23/1987 23 1X M 2 F Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits 1 XXYes 2 No Temple Hills or 28a-f show Prince George' must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene. Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2510 Iverson Street 20748 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes Specify Black 3 Widowed 1 Yes 2 No specify: 4 Divorced If Yes, Give Yeer 5 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Sales Person Pizza Hut 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles Morse Winnie Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9012 Little Stone Dr. FtWashington, MD 20744 If item 27 Renee Carroll/ Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/28/2011 Waldorf, MD Important: Heritage Mem.Cem. Donation 5 Other Specify 21. Si pature of Funeral Service Licens 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, Physician 23a. Payl I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line. /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of); events resulting in death) Last and - transit Division of Vital Records, P.O. Box 68760, ital or Attending Physician: The law requires that the death certificate be executed Physician/Medical the attending physician ed for use as the burial -UNPENDED **AMENDED** IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Day Year detached for use as 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part 1. signed b <u>۾</u> 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury 28c. Injury at Work? 28b, Time of Injury 28d. Describe how injury occurred 27. Manner of Death Subject shot 1 Natural May 17, 2011 0153 hrs 1 Yes 2 ✔ No Pending hours after death filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 610 Modoc Lane, Forest Heights, MD determined (Specify) Local Street 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar's Signatur 31. Date filed (Month, Day, Year)

**OCME** 

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

May 17, 2011

DHMH 17 Rev 1/2001

State

Registrar

Ane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 05 12:13P M Ernest P. Coulson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2888 Biggs Highway Ceci1 North East If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 🗆 F Month Pay / 1925 Director 85 MD 216-20-3156 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Tes 2 X No Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2888 Biggs Highway 21901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Retai1 Store Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Eli Coulson Ella Parson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Heilander - daughter 2888 Biggs Highway, North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Removal from State West Nottingham Cem. 05/28/2011 4 ☐ Donation 5 ☐ Other (Specify) Colora, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen Street, Rising Sun, MD 21911 Enter the disease, or complication e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of Immediate Cause (Final Interval Between Unknown provascular Physician/ disease or condition Medical resulting in death) **Examiner** Aftero coleros es Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires: within 24 hours after death. To the Funeral Director: After this certificate has been sion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 \( \sum \) Nursing Home 5 \( \begin{array}{ccccc} \text{Residence} & 6 \sup \text{Other} \) Other (Specify) ျှ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of Pertifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY <sup>Day</sup> 2011 Physician/ 3:50 A M WARREN D. DAVIS, Sr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. July 3 PA 194-40-5826 **Director** 59 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location must be notified at Funeral Director 1 X Yes 2 ☐ No Prince George's Largo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a 1023 Drexelgate Lane 20774 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 2 'natural", or 1 Never Married 2 K Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working than Elementary/Seconday (0-12) College (1-4 or 5+) Government and Mental Hygiene. is marked other tha Air Traffic Controller Spec 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bessie L. Price Richard Jarrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1023 Drexelgate Lane, Largo, Maryland 20774 <u>Victoria K. Davis/Wi</u>fe 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Penoval from State Maryland Veterans June 6, 2011 Cheltenham, Maryland 4 Donation 5 Other (Specific Cheltenham 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licer 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ disease or condition resulting in death) Medical quence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the page 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hemochal Disease on Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 **N**o 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending after death. Director: Aft 1 Yes 2 No Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number D0055120 May 23rd 2011 m) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD PALMER southern avenue SE into 310 Workington DC 20032 1328 31. Date filed (Month, Day, Year) MAY 2 7 2011 State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 4:35 a M 2011 1000 May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Cecil Examiner E1kton Laurelwood Care Center 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs **Funeral** Days Months (Month, Day Year) 936 215-34-6149 1**X** M 2 □ F Hours 74 Director Aug. Pennsylvania Usual Residence of Decedent or 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Port Deposit Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21904 U.S.A. 33 Honeysuckle Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White I Hygiene. other than "natural", If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) A-1 Salvage Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Havre de Grace, Maryland Twelve Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Margett Shaw Frank W. Dinsmoor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
33 Honeysuckle Drive, Port Deposit, Maryland 21904 19a. Informant's Name/Relationship (Type, Print) Labon I. Maple Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Port Deposit, 1 Durial 2 Cremation 3 Removal from State ō injury 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 05/25/11 Maryland Sign ture of Funeral Service License 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, 21903-0766 <u>Maryland</u> Perryville. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Me disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consecuence of Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 😾 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred work? injury 1 Natural 5 Pending 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu death. Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 21610 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5 2011 Harvey George Elliott, Jr. 8:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 409 Linden Ave. Apt. Pocomoke City Worcester 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 1 🕱 M 2 🗆 F Hours Min 74 Yrs. Director 216-38-9481 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director MD 1 Yes 2 X No Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 1210 Market St. Apt. 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 X Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harvey G. Elliott, Onieda Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celia Ann Murray (daughter) Pryor Ave. Salisbury, MD 21804 108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State First State Crem. 05/20/2011 |Millsboro, DE 4 Donation 5 Other (Specify) 21. Signature of Funer ervice Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death TSUD Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nonsequence of Examin that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant g Unknown Other (specify) Pregnant at time of death ed by the a detached t g 🔲 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law autopsy this certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, i Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Girlfriend! Other: 4 Nursing Home 5 Residence 6 Other (Se 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Cettifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) H5049) 5/18/11 30. Name and address of po pleted cause of death (Item 23a) (Type, Print) 100 E Carroll St. nus 21801 05 DME

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 4 2011

Warester

32 Registrar's Signature

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a 241

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address

31. Date filed (Month, Day,

MAY 2 7 2011

29c. License number

more Are Hyattsville mis

29d. Date signed (Month, Day, Year)

## Baltimore, Maryland 21215-0036

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Physicia Medic		Richard	,	,					May	23 <sup>ay</sup>	20 T	12:40a M
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Funeral Director		220-34-6		1 <b>X</b> M 2 □ F	Age (In yrs. I	73 Yrs.		Hours Mi			9. Birth	place (State or Foreign htry) MD
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ld be f Menta arked atic ev	잍	Paul Eld:	reth					Jane M	cCauley			
shoul h and 7 is m rraum:		19a. Informant's Na				1	g Address (Street an					Code)
and 2 Healt tem 2		Mabel Ele 20a. Method of Disp		wite	20b. P		I. Hills D	r. Kis	ing Sun,	MD Z19	· · · · ·	own State
Page 1 nent of int: If i			☐ Cremation 3 5 ☐ Other (Sp	3 ☐ Removal from State	ate c	emetery, cren	natory or other place) ant Cemet	ery 5/		Colora	•	own, state
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lic	censee	1.	22	. Name and Address	of Facility	1			
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Physician/		shock or hear Immediate Cause (	rt failure. List on Final	ly one called on each	ne.	N DO NOT ONCE	the mode of dying,	odon do odra	ao or roophatory an	001,		Approximate Interval Between Onset and Death
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oital or urs aft ral Dir illed in					etc. (Specify)				City or Tow			
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Lunaral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2		Physician: To the best aminer: On the basis of lurse Practioner: To t	of examination	and/or investi	gation, in my opinion,	death occurre	d at the time, date a	nd place, and	due to the ca	use(s) and manner stated.
vithir comp		29b. Signature and t		1.0	1		29c. License n			29d. Date sign		
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 00 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ам 2011 Stephen Farmer 10:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 2709 Newglen Avenue District Heights 9. Birthplace (State or Foreign Sex 1 M 2 □ F . Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Days Hours 03/26/1964 47<sup>Yrs</sup> Washington, DC Director 217-90-9816 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Prince Georges District Heights 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2709 Newglen Avenue 20747 items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No , or . Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Black th Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) <u>Environmental</u> <u>Specialist</u> Private other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည C. Lawson Farmer Viola Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) District Heights, MD 20747 Vikky Earle – Sister 2709 Newglen Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) Lincoln Cemetery 05/23/2011 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Montgon 3401 Bladensburg Road Brentwood, 20722 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOVASCULAR DISEASE HTHEROSCLEROTIC disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** HYPERTENS JUXNOWN if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital the funeral director, Be 26. Place of Death (Check only one) xaminer? Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 A Homicide determined Medical 29a. Certifier 🔏 Certifying Physician To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Oh the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title 29c. License number 30. Name and address of person ted cause d death (Item 23a) (Type Print) TUTH WAL State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2Day 2011 1230 PM Mary Bryan Ford Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Easton Taibot Hasputai at Easton Memorial If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth
(Month, Day, Year)
December 19,1931 9. Birthplace (State or Foreign Funeral Maryland 1 M 2 X F 220-26-9146 79 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Caroline Denton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21629 312 South Fifth Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Completed 3 Widowed 4X Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11 H.S. Grad. College (1-4 or 5+) Page 1 and 2 should be filed within Homemaker Family 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cora Rebecca Carroll Norman Legg Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denton, Maryland 21629 312 South Fifth Avenue Amanda Lewis/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of H 1 Burial 2 XCremation 3 Removal from State Dover, Delaware Captiol Crematory May 24, 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service I Moore Funeral Home, P.A. 22. Name and Address of Facility duch Denton, Maryland 21629 12 South Second Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or se a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify, 1 K Inpatient 2 🗆 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

address of person who co

DHMH 17 Rev 7/2009

mpleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

140 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2011

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 20:50P M Physician 20 Sherrica Mai /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF MARCH 16, 1977 MICHIGAN 34 Director 379-94-5465 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No MD PRINCE GEORGE UPPER MARLBORO Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 12421 ALAMANCE WAY 20772 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after ( Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify SpecifyBLACK þ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than CONSULTANT PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F CYRENTHIA BROWN ည WALTER STEELE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau RODNEY A. GREEN/HUSBAND 12421 ALAMANCE WAY UPPER MARLBORO, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 5-27-2011 CLINTON, MD Funeral Service Lice see 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease. shock, or heart failure. List only one cause on each line. Immediate Cause (Final holangio Carlinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of The law requires that the death certificate be executed that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE: yes, outcome of pregnancy ☑ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months?
1 X Yes 2 □ No Day Pregnant at time of death 5 Other (specify) 2011 ate has been signed by the a page 2 should be detached 3. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death Check onl one) Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Lor Attending Patter to Director: After t Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide e Hospital 29a. Certifier (check only 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dearborn 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's S State MAY 2 6 2011

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:58PM VANESSA FERN May 18, GORDON Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Lanham 6815 Forbes Blvd. Prince Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year 1 □ M 2 🖳 F New York 48 050-50-1514 **Director** Usual Residence of Decedent or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** Lanham 1 Xes 2 No Maryland Prince Georges 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 20706 AZU 6815 Forbes Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 XNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) National Security Adm. Analyst Be 18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Rawlins 17. Father's Name (First, Middle, Last) ည Gerald Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6601 North 52nd Street, Tacoma, WA Dorothy Gordon / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 05-25-11 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Strickland Funeral Services 22. Name and Address of Facility Signature | f Funeral Service 6500 Allentown Rd, Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. erval Between Onset and Death Immediate Cause (Final Ph sician/ TRICULA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe after death.

Director: After this certificate h 2 XNo 1 ☐ Yes 2 🔊 ☐ Yes сотрые filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗆 No 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie 29d. Date signed (Month, Day, Year) ngleted cause of death (Item 23a) (Type, Print)

State Registrar 31 Date filed (Month, Day

MAY 2 6 2011

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LOWITZ

3700 Reservoin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 5:50 James Nelson Grant 2011 Medical May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 155 Bayscape Drive Perryville Cecil 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 10. 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 1 ★ M 2 □ F Days Hours 212-38-2640 Months Director 70 940 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Maryland Cecil Perryville 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 155 Bayscape Drive U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry
V.A. Medical Center Elementary/Seconday (0-12)
Twelve Years .DO NOT use retired) Conditioner/Refrigeration College (1-4 or 5+) Perry Point, Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley McKinley Grant Josephine Ragan permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)
Crant Hill (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Herbst Lane, Perryville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 05/26/11 Pennsylvánia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P
Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ small cell cavernana disease or condition 242005 Medical resulting in death) Due to (or as a consequence of): Examiner tobacio usas Sequentially list conditions, if any leading to in realist cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 L Yes 2 L 9 Dnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? Ś sign. Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 
Nursing Home this : After this funeral of 27, Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) P0063610 23 May MD 2011

9+0 IVA

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Date filed (Month, Day, )

Registrar

DHMH 17 Rev 7/2009

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MD

Bata Blud Belcays

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

103A

items 23a or 28a-f shov ner must be notified at death with the Maryland "natural", or item ledical Examiner n filed within 72 hours after Baltimore, Maryland 21215-0036 Medical

State Registrar

I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 22 2011 7:40 P M HALL JOANNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SUITLAND 6107 AUTH ROAD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. WASHINGTON, DC 61 1950 Director 219-54-7443 MARCH Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 x Yes 2 □ No MD PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20746 6107 AUTH ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 XNo Yes BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nr any injury or other traumatic event, the Medit once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>HOUSEWIFE</u> PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARY VIRGINIA DAVIS RANDOLPH THOMAS HALL SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 GOULD DRIVE DISTRICT HEIGHTS, MARYLAND 20747 CHARLENE COLEMAN/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, RIVERDALE CREMATORY : 5/28/2011 RIVERDALE, MARYLAND 21. Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day ģ Month Year Pregnant at time of death 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Tes 2 No 3 Probably 4X Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy performed? Yes 2 No death? certificate 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 K Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the form 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 24, 2011 D08754 MAY no completed cause of death (Item 23a) (Type, Print) THOMAS BEN INGER M.D. 7525 GREENWAY CENTER DRIVE #205 GREENBELT, MARYLAND 20770 31. Date filed (Month, Day 32. Registr State MAY 2 6 2011 Registrar

amenia 1700 or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month Year Lillian M. Hare 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomic lisburg Salisbury Rehabilitation & Nursing Ctr Birthplace (State or Foreign Country) 6. Sex 1 ☐ M 2 🛣 F If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Months 90 6 10 94 920 220-01**-**2551 **Director** MD Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Wicomico Director 1 Yes 2X No Pittsville MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21850 USA 34799 Sandyfield Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify: Specify 3X Widowed 4 ☐ Divorced white Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Hospitality 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lavenia Hamblin John J. Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34799 Sandyfield Dr., Pittsville, MD 21850 Shirley Records / niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pittsville Cem. 5/20/2011 Pittsville, MD 4 ☐ Donation 5 ☐ 9ther (Specify) 21. Signature of une rvice Licensee 22. Name and Address of Facility Burbage Funeral Home William St., Berlin, MD 21811 108 23a. Part 1. Enter the disease, or complications that gained the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on eag Interval Between Onset and Death act Immediate Cause (Final Physician/ disease or condition resulting in death) a can-Medical Due to for as a consequence of) Examiner entially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transli that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant a
9 Unknown Pregnant at time of death 2 No sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 🗆 Yes 2 🗆 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director, A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

William H. Robin

2

31. Date filed (Month, Day, Year)

MID

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #23e, per physician, 6/3/11 Certificate of Death E.T. Amended item WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 21, <sup>D</sup>2011 Year ETHEL LUCILLE WILLIAMS HANCOCK 8:36A M Medical Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Sallsburg 100m100 Social Security Number If Under 1 Year If Under 24 Irs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 😾 F Min Months Hours Director 226-30-3782 01/09/1931 Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD Worcester Pocomoke City 1 √ Yes 2 □ No 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 409 Linden Ave., Apt. 201 21851 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Fthe Hancoc Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marvin Williams Kathryn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 8 5 1 Michael Howard/ Son 2445 Lakeland Drive, Pocomoke City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)

Beth Eden Tilghman Hill Cem. 5/24/201 Pocomoke, MD ure of Fundal Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P. A. 107 Vine St., Pocomoke City, MD 21851 107 Vine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) wig Carcin Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Trobably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? After this certificate 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 0 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending death. Accident 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) the 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN SHOPE DR SALISBURY, MD, 21804 VOHLA 8A6 YOGEBH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAY 24

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 30 Harle onald A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 8408 Beruick 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Days 1 🛮 M 2 🗆 F Months Hours Min 214-58 2009 Director Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) trelyn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 27-11 ON 21. Signature of Funeral Service Licensee Name and Address of Facility Lases 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death ESOPHA GEAL CARLINOMA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 4 Pregnant
9 Unknown Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 X No Hospital: Certificate: To 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELSON BENJERS M.D., 9131 PISC MEMONY PD, CLINTON,

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 22<sup>Day</sup> May Month **Physician** 2011 Sarah Katherine Iacona /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline 900 Gay Street Apt. D Denton If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 ☐ M 2 🔀 F Min. Director 526-11-5556 December 21.1945 65 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating until be notified at 10d. Inside City Limits Director 1 Tyles 2 □ No Denton Maryland Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 900 Gay Street Apt. D U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▓ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: þ 1 ☐ Yes 2 No 3 M Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Family Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Washington Stubbs, Sr. Eleanor Virginia Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Moore/daughter 7799 Orange Drive Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory May 24, 2011 Dover, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part1. Enter the disease of complications that caused the shock, or heart failure. We tonly one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** r as a consequence /) /Medical Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Dan to for as a nonsequence offi-Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 1 Yes 2 No Medical Certification: To 5. Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760

Division of Vital

32. Regiatrar's

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monthay 29, 2011 Lorrainne Judv 3:10 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13714 Brant Road Cresaptown Allegany 5. Social Security Number 7. Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD Days 1 M 2 J Hours Jun 77 Director 220-26-7683 81 Usual Residence of Decedent or 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. Count Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Cresaptown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13714 Brant Road 21502 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ō 1 Never Married 2 Married 1 Yes 2 No Black, White, etc. Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No "natural", Specify 3 Nidowed 4 Divorced Specify: white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important if item 27 is marked other than any injury or other transmate. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dewey E. Duckworth Martha A. (Jewell) Duckworth 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Forest Avenue LaVale MD 21502 Theresa Deffenbaugh niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Memorial Park 6/2/2011 Cumberland MD 4 Donation 5 Other (Specify) Sonature of Funeral Service Livensee 22. Name and Address if Full Heral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Chronic Ubstructive disease or condition resulting in death) Medical **Examiner** tic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or sician and burial-transit requires that the death certificate be executed acic that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed? Yes 2 No death? this certificate To the Hospital or Attending Physician: within 24 hours after death. completed filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗶 No Hospital Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 🗙 Residence 6 🗆 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? After 28d. Describe how injury occurred 5 Pending Accident Suicide Investigation 1 Tes 2 🗆 No Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 0056080 Medical Director Name and address of person who completed cause of death (Item 23a) (Type, Print) 17204 mcmullen Hwg Allison Evans-Wood D.O. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health an	nd Mental H	ygiene	11 18378						
			1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)	2. Date of D	Reg. No.	3. Time of Death						
	Physicia		Roger Lee Kibler	Month		2011 0959 AM						
	Medic Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De		4c. Coun	nty of Death						
			Memorial Hospital @ Easton Easton		اء	albot						
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Hrs. 8. Date of B Viin. (Month, I July 3	orth Day, Year)	9. Birthplace (State or Foreign Country) Maryland						
			Usual Residence of Decedent	литу э	. 1932	Maryland						
	yland -f sho ed at	ctor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
	ne Mai or 28a notifi	Dire	Maryland Caroline Denton  10e. Street and Number 10f. Zip Code		10a Citizan o	1 Yes 2 □ No of What Country?						
	with the	Funeral Director	P.O. Box 517 21629		USA	in What Godinity:						
	leath items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No		ace - American Indian,						
9	after of I", or xamin	d by	1 X Never Married 2 Married 1 Tyes 2 X No	derto riiodii, cto.,		lack, White, etc.						
2-002a	nours latura ical E	letec	Year or Dates.  15. Decedent's Education  16a. Decedent's Usual Occupation			White Business Industry						
מ	in 72 l e. nan "r Med	Completed	(Specify only highest grade completed)  [Give kind of work done during most of life. DO NOT use retired)  [Give kind of work done during most of life. DO NOT use retired)  [Laborer	working								
7	d with lygien ther th	Be C			Constr							
מבום	be file antal H ked of c ever	To B	Tohn Tarmonco Wihlow	Name (First, Middl Ellen Com		me)						
ary	nould ind Me		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			, State, Zip Code)						
Ž	nd 2 sł salth a nn 27 ii ertra		Elizabeth Ann Roe/sister 4334 Waddells Corner									
ore	ge 1 ar t of He If iter or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location	n - City or Town, State						
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specify) Greensboro Cemetery Jur									
0	permi Depar Impor any ir	- 1	21. Signature of Funeral Service Licensee  Figure and Address of Facilitie  F.O. Box 160, Gre	enbein Fu ensboro.	neral Ho Marvlan	ome, P.A ad 21639						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.			Approximate Interval Between						
~ P	husician/	0 1	Immediate Cause (Final disease or condition  Acute must condition	fort	Em	Onset and Death						
	Medical Examiner		resulting in death)	1								
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			_						
	uted d ansit	amir	cause. Enver underrying Cause (Disease or iinjury that initiated events  c.									
	e exec sian an urial-tr	dical Examiner	resulting in death) Last  Due to (or as a consequence of):									
20	To the Hospital or Attending Physicians: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  When Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		d									
00	certific nding use as	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. [	Date of delivery						
ב ב	death ne atte ed for	Physician/Me	in the past 12 months?  1			Month Day Year						
	at the d by th etache		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did	tobacco use co	ntribute to the cause of death?						
L	ires th signe d be d	d by	Person Constant			3 Probably 4 Unknown						
ecords,	v requ	Completed	Cirrhosis	24a. Wa	s an 24b	o. Were autopsy findings available						
ָ בּ	The lav ate has	you	heputits C  autopsy prior to completion of cause of death?  1   Yes 2   No   1   Yes 2   No									
. 0	cian: 7 ertifica ector, 6	Be (	25. Was case referred to medical examiner?									
>	Physic this c	은	1 Yes 2 No Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at	ng Home 5 🗆 Re								
Õ :	nding tth. ; After e fune	cate	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation (Month, Day, Year) M I Tyes 2 No		how injury occu	urrea						
VISION	r Atter ter dea rector by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Num	nber or Rural Route Number,						
5	oital o urs aft ral Di											
:	Hosp 24 ho Fune leted f	Medical	29a. Certifier  1	red at the time, date	and place, and o	due to the cause(s) and manner stated.						
	To the comp	2	29b. Signature and title of certifier  29c. License number		29d. Date sign	ned (Month, Day, Year)						
			1 1 cm 6400	13	: nay	50, 2011						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PAUL W, Moveto 2195, Weshingth-St. E	Asjon	, us	30, 2011 21601						
	Stat		31. Date filed (Month, Day, Year)									
	Registra	ır	70.00									

DHMH 17 Rev 7/2009

			State of Maryland / Department of Health and N	Mental Hygiene					
			1 - State Registrar Certificate of Death	Reg. No.2 0 1 18379					
	Physicia Medi	cal	Decedent's Name (First, Middle, Last)  HELEN T. KAESER  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	2. Date of Death Month Day Year 3. Time of Death 18.27 P					
-	Examir	ıer	Calvert Manor Health Care Center Rising Sun,						
	Funeral Director		5. Social Security Number 101-10-8957  6. Sex 1	8. Date of Birth (Month, Day, Year) 3/16/1916  9. Birthplace (State or Foreign Country) Brooklyn, NY					
	Maryland 28a-f shov otified at	Director	MD Cecil 10c. City, Town or Location Warwick	10d. Inside City Limits 1 ☐ Yes 2 ☑ No					
	vith the 23a or st be n	al D	10e. Street and Number  2 Preakness Place  21912	10g. Citizen of What Country? USA					
9200	filed within 72 hours after death with the Maryland al Hygiene.  Jother than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at	ted by Funeral	11. Marital Status  1	secify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White					
15-(	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. Do NOT use retired) (if. Do NOT use retired)	16b. Kind of Business Industry					
212	led within Hygiene.  other tha ent, the N	Be Co	8th Homemaker	Domestic/Own Home					
land	0 4 6 0	일		ne (First, Middle, Maiden Surname) Le Greiner					
Maryland 21215-0036	d 2 should be file alth and Mental P 127 is marked o or traumatic eve			ral Route Number, City or Town, State, Zip Code)					
Baltimore,	age 1 and 2 s ent of Health nt: If item 27 i y or other tre		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) United Crematory Srv.	Date 20c. Location - City or Town, State					
Baltir	permit. Page 1 a Department of F Important: If ite any injury or ot	1 8 0 0	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	HISON FUNERAL HOME LLC					
	Medical Examiner  Per burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	23d. Date of delivery Month Day Year					
Division of Vital Records, P.O.	v requires that the state of th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown					
Recor	The law requir	Completed by	`	24a. Was an autopsy performed?  1 □ Yes 2 ☑ No  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No					
Vital	ysician: s certifi director	To Be	25. Was case referred to medical examiner? 1	k only one)  ome 5 □ Residence 6 □ Other (Specify)					
Jo L	ing Phy I. After thi uneral c		27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of injury 28b. Time of injury work?	28d. Describe how injury occurred					
ivisior	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	e Hospita 24 hours e Funeral	Medical	29a. Certifier (Check conly one)  3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place and pla	it the time, date and place, and due to the cause(s) and manner stated					
	To the within to the comp	<	29b. Signature and title of certifier  29c. License number  D0078354	29d. Date signed (Month, Day, Year)					
	10	10	BO. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WELL E. LATTIN, M.D., 101 COLONIAL Way, Rising	Sun MO 21911					
	Stat		31. Date filed (Month, Day, Year)  MAY 25 2011  32. Registar's Signature  MAY 25 2011	3					
	Registra	ar	MATEU CUIT Chrown B. garker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

P-10-1	8	3	8	0
	200	pet.	4,7	

		1- For State Control of The attraction of the at		eg. No.	
Physicia Vedical Examin	11/4	1. Decedent's Name (First, Middle, Last)  Arthur Luckett	2. Date of Deal Month May 18, 20	Day Year	3. Time of Death 1515 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location  Prince George's Hospital  Cheverly		4c. County of Death Prince George	
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 5 7 8 - 74 - 21 20 1 X M 2 F 5 7 Yrs.	th(MM/DD/YYYY) 9. Bir 7-1954 Foreig	thplace (State or in untry) MD	
nd show any	يا	Usual Residence of Decedent  10a. State			10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	흠	10e. Street and Number 2910 Brightseat Road 2078		0g. Citizen of What Cour	ntry?
er death wi	Funeral	11. Marital Status 1 Never Married 2 Married   12. Was Decedent Ever in U.S.   13. Was Decedent of Hispanic Or   14. If Yes, specify Cuban, Mexican   15. If Yes, specify Cuban, Mexican   16. If Yes, specify Cuban, Mexican   17. If Yes, specify Cuban, Mexican   18. If Yes, specify Cuban, Mexican   19. If Ye	n, Puerto Rican, etc.)	White, etc.	can Indian, Black,
36 in 72 hours af isan "natural"	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  To Dates:  16a. Decedent's Usual Occupation (Give during most of working life. DO NO1	kind of work done ruse retired)	16b. Kind of Business/I	ndustry
	Be Com	17. Father's Name (First, Middle, Last) 18.Mothe	r's Name (First, Middle, M he1 Lucket		
MD 2121 d 2 should be f Ith and Mental n 27 is marked numatic event,	]۲	19a. Informant's Name/Relationship (Type, Print)  Ethel Luckett (Mother)  19b. Mailing Address (Street and Num 2910 Brightsea Landover, Mary	mber of Rural Route Num t Road 1and 20		
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Harmony Mem. Pk.			c, MD
		2 ign ture of Funeral Service Lizensse Rand Address of Facility 100 Million 10	nsDelight	Dr.,Bowie	ice P.A., MD 20720 Approximate Interval
Physician //Medical :xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Cardiovascular D Due to (or as a consequence of):		or, orlow, or neutr	Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Closese rights) the light that is lightly the cause of the			
ecuted and transit	ai Examine	events resulting in death) Last  Due to (or as a consequence of):  d.			
760, iteate be executed by physician and the burial - transit	Medicai		m 	23d. Date of delivery	
certif	Physician/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectoping the past 12 months?  1 Yes 2 No 9 Unknown 5 Other (Specify) 9 Unknown	c pregnancy	Month D	ay Year
P.O. es that the igned by	[র	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P		bacco use contribute to	
Division of Vital Records, P.O. Box sal or Attending Physician: The law requires that the death safter death.  al Director: After this certificate has been signed by the attended in by the funeral director, page 2 should be detached for u.	Completed		24a. Was a autops perfor 1 ✓ Yes 2	sy prior to c m <u>ed</u> ? death?	topsy findings available ompletion of cause of
Vital hysician: this certi	98 2-	25. Was case referred to medical examiner?  1 ✓ Yes 2 No    No   No   No   No   No   No   No		Residence 6 Other	:
Division of Vital Recc To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate ha	ation:	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Worl  1 Yes 2	] No	ow injury occurred	
Divis	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, e	tc. 28f. Location (S or Town, St	treet and Number or Rui	ral Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Directors	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or and manner stated.		and place, and due to the	e cause(s)
	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.		29d. Date signed <i>(Mor</i>	ith, Day, Year)
2	200	3 Name and Idress of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street,	Baltimore, MD 212	223	
Sta Registr	te ar	31. Date filed (Month, Day Year)  A 2 7 201  Server S. Sauck	7 - 1 =		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2011 18381 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5/21/2011 Physician/ :15 P Julia Adele Lloyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin 8 Mulberry Lane 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number Days 1 □ M 2 🕱 F Director Washington DC 218**-**24**-**1187 Usual Residence of Decedent 23a or 28a-f show J. Hygiene. other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Yes XX No 10f. Zip Code 10g Citizen of What Country? Funeral 8 Mulberry Lane 21811 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2X No Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fishers is marked of မ Anton Ostmann Mary Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Emerson Lloyd (husband) 8 Mulberry Lane Berlin, MD 21811 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State any injury or 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 1st State Crematory 5/23/2011 Millsboro, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Service License Funer 23a. Part 1. Enter the disease, or complications th t caused the death. Do not enter the mode of dying, such as cardiac or respiratory grest, each line. Approximate shock, or heart failure. List only one cause Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 phy: anding p IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autonsv performed? page 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 **1** No Hospital 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination a random model at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 028798 5-2-2011 cause of death (tem 23a) (Type, Print) 30. Name and address of person who completed Lilah C. Gonzalez MD 314 Franklin Ave. Suite 104, Berlin, MD 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CURT LIPPOLDT, JR. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO \$12/36411 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 7. Age (In yrs. last birthday) Month, Day, Days Hours 1 🌠 M 2 🗆 F 528-24-9996 Colorado Director 1926 85 May Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director Yes 2 No Pocomoke City MD Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21851 13 Front Street items death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 1 Ves 2 □ No If Yes, Give "natural", or 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 3 ▼Widowed 4 □ Divorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working iffe. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Marie Hunter Curt Lippoldt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Front Street, Pocomoke city, MD 21851 Valerie Woods/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cem. 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/21/2011 Pocomoke, Md 22. Name and Address of Facility Holloway Funeral Home, Signatore of Fune Service Licensee MD 21851 107 Vine Street, Pocomoke City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between set and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, arolfomyrpath Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan performe Yes 2 € 1 Yes 2 No Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and ti

BA 10+1

State Registrar Christian D.

31. Date filed (Month, Day, Year) MAY 2 4 2011

106 milford St 605 Salisbury.

address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Pégistrar's Signatur

Bounds

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT DALE MAY 2011 LAWSON 11:00 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 645 Knights Island Rd. Glen 8 Lot 8 Cecil Georgetown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Pay,
June 15 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★M 2 ☐ F 1940 159-32-4174 70 Pennsylvania **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f sho event, the Madical Evantian must be motified at Director 1 ☐ Yes 2 XNo MD Cecil Georgetown or 28a-f 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21930 645 Knights Island Rd. Glen 8 Lot 8 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important; if Item 27 is marked other the any injury or other traumation. Master Dyer Textile Manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Lawson Catherine O'Rourke ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gusky (daughter) 41137 Revines Edge Way LaGrange, OH. 44050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Kent Cremation Services 5/26/11 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faner (Serv Galena Funeral Home of Stephen L. Sci 118 West Cross St. Galena, MD. 21635 M00510 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, illure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 Enter the shock, or heart Immediate Cause inal disease or control on resulting in th) **Physician** Condini /Medical Due to (or as a consequence of): Examiner 00 m Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? 1 □ Yes 2 X No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by t death. investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who comple

31. Date filed (Month,

Paul M. Katz, DO

WAY 25 201

251 S. Bohemia Ave. Cecilton, MD. 21913

ted cause of death (Item 23a) (Type, Print)

14056426

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $\mathbf{P}_{\mathsf{M}}$ Physician/ Day ROSETTA MILNER MAY 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL CENTER PRINCE GEORGE'S CHEVERLY . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Hours Min Months 11/18/1927 NC **Director** 242-42-5684 83 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a State 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Prince George's Capitol Heights Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 20743 United States 5723 Eagle Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3x Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Office Manager Private other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ige 1 and 2 should be filed nt of Health and Mental H t: If item 27 is marked ot or other traumatic ever 2 Robert McNair Negolia Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4104\ Vine\ Street,\ Capitol\ Heights,\ MD\ 20743$ 19a. Informant's Name/Relationship (Type, Print) Patricia A. Davis/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4 Donation 5 Other (Specify 06/06/2011 Cheltenham, Maryland Signature of Funeral Service Lice 22. Name and Address of FacilityPope Funeral Homes, P.A. MOION 5538 Marlboro Pike, Forestville, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Urinary Tract Infection and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Pneumonia Division of Vital Records, P.O. Box 68760 the as attending IE FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 🗌 Yes 2 🗌 No 3 🗌 Probably 4 🔀 Unknown Completed Chronic Atrial Fibrillation Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Anoxic Encephalopathy 1 ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 X No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending s after death. I Director; Aft Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

completed :

29a. Certifier

(Check only one)

29b. Signature and tipe of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month. Day. Year)

25, 2011

MAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year JOHN FRANKLIN MILLER, JR. 252 My 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NICOMICO Medical REGIONAL SHISbUCH TENIN SULLA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **ec** • 6 , 1 ₹ M 2 □ F Hours Min 73 Pennsylvania Director 198-26-2668 1937 Dec. Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Market Street Apt. 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Franklin Miller, Sr. Dorothy Esther Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 8 5 1 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Brenda Miller/ Daughter 106 Front Street, Pocomoke City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State First Bapt. Cem 5/25/2011 Pocomoke City, MD Important: It any injury or 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home, P.A. 107 Vine Street, Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ptu red abdominal Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of Exami The law requires that the death certificate be executed Cause (Disease or iinjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical e attending phy 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the a 1 | Yes 2 L 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗆 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Hospital: Other: 2 9 No ဂ္ 1 Inpatient 2 I ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Aft bleted filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and class to the administratory and are within 2 29b. Signature and title of gerlifier D53551

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

R.M.C.

100 E. Carroll St.

son who completed cause of death (Item 23a) (Type, Print)

	1	For State Registrar	State of Ma	aryland /	-	artment of Fi rtificate of I		ınd Mer		eg. No.	0 1 1	8386
Physicia /Medica	n	Decedent's Name (First, Middle,  JOHN		EARES					Date of Dea Month IAY 24	Day	Year	3. Time of Death 1:56 A M
Examine	-	4a. Facility Name (If not institution, 2 FETA COURT	give stre <b>e</b> t and number)			4b. City, Town, or UPPER MA					unty of Death	EORGE'S
Funeral Director			1 X M 2 □ E	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day IAN 21	, Year)	9. Birth Cou FLOI	place (State or Foreign intry) RDIA
laryland show	jo.	Usual Residence of Decedent  10a. State 10b. County		10c. City, To								10d. Inside City Limits 1X Yes 2 □ No
ite, IMalylalid ZIZIS-DUSO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	MD         PRINCE           10e. Street and Number         2           2         FETA COURT	GEORGE'S			LBORO 10f. Zip Code 2077				USA	of What Cou	
ours after de ral", or Items	ğ	11. Marital Status  1 □ Never Married 2X Marrie  3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? d 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	ever in U.S.		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2ሺ No	Specify:	gin? (Speciry i, Puerto Ric	an, etc.)	Sp	Black, White	, etc. WHITE
I Z I Z I Z I Z I Z I Z I Z I Z I Z I Z	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5		(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	oation during most d)	t of working		16b. Kind o	of Business/I	
aryiario z 1.2 should be filed withi and Mental Hyglene. s marked other than umatic event, the M	To Be C	17. Father's Name (First, Middle, La RICHARD MEARE		'				r's Name <i>(F</i>	irst, Middle,	Maiden Sui	rname)	
(e, Maly		19a. Informant's Name/Relationship MARY LEE MEARE		1		ng Address (Street CTA COURT		R MARI	LBORO,1	MARYLA	AND 20	774
Dallillore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	ecify)	ceme	etery, crei EMONT		RY	6/4/2			SONVIL	Fown, State
Dermit Depar Impor any in		21. Signature of Funeral Service Li	hall		1 7	2. Name and Addre	OVER I	'J. B. ROAD F	YATTSY	VILLE.		HOME, INC. AND 20785 Approximate
Physician /Medical		23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. CORONA	RY ATH	EROS	CLEROSIS	ng, such as	cardiac or n	espiratory an	est,	,	Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CONGES  Due to (or as	TIVE H	EART	FAILURE		_				
ficate be executed physician and is the burial-transit	edical Exan	that initiated events resulting in death) Last	c	a consequenc	ce of):							
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea	ath 3∐	Ectopic pregnancy Other (specify)	у			23d	. Date of deli Month	very Day Year
w requires that been signed by should be deta	2	Part II. Other significant condition	ns contributing to death be	ut not resulting	g in the u	nderlying cause giv	en in Part I.			obacco use ′es 2 <u>∏</u> N		the cause of death?
The law recate has been page 2 shou	Completed										24b. Were au prior to d death? 1 □ Yes	topsy findings available completion of cause of 2 🖾 No
Physician: Physician: r this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:			ot 3DDOA Oth	er.		Check only o			
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 290 Place of init	ury - At home c. (Specify)	, farm, str	reet, factory, office		28f	f. Location (S City or Tox		lumber or Ru	ural Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	Medical C		Physician: To the best xaminer: On the basis of and manner sta	f examination								
To ti withi To ti	×	29b. Signature and title of certifier	3			29c. Licens	se number				igned <i>(Monti</i>	
230			D. 2009 TID	EWATER	COL	Print)		APOLIS	,MARYI			
Stat Registra		31. Date filed (Month, Day, Year) MAY 2 6 2011	Annu ) A	ar's Signature	ومط							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items2,29d per phys. g916 6-9-11 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William McCullough 11:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 410 Race Street Cumberland Allegany 5. Social Security Number Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Month, Day Months Hours Director 217-10-1632 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a --- any injury or other traumatic event, the Modification of the property of the modification of the modification of the property of the property of the modification of the property of the modification of the property of the modification of the property of the property of the property of the modification of the property of th 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Cumberland Allegany 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 410 Race Street 21502 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: If Yes, Give Year or Dates WW II Specify 3 Widowed 4 Divorced white Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Davy Supply Co sheet metal worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary E. (Bishop) McCullough Lee McCullough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 New Hampshire Ave. Cumberland MD 21502 Carol Clise daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery Date 20c. Location - City or Town, State 🛛 Burial 2 🗆 Cremation 3 🗀 Removal from State 6/2/2011 MD Flintstone 4 Donation 5 Other (Specify) 21. Signature CF uneral Service Licenses 22. Name and Address of Facility Page 1979. PA 108 Virginia Avenue; Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Chronic renal failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year Day 1 ☐ Yes ≥ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Hypothyroid, COPD, Dementia 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 은 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 27. Manner of D ath Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direct Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 2011 May 30 <del>2001</del> person who completed cause of death (Item 23a) (Type, Print) 24 31. Date filed (Monty Day Year) 2011 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Otate of Warylar		tificate of D			Reg. N		18388	3
Physici Medi		1. Decedent's Name (First, Middle, Last, Elizabeth	McDonald				2. Date of Do	21,2	7011 Year	3. Time of Death 10:05 Av	1
Exami		4a. Facility Name (if not institution, give s 7606 Martha Street	treet and number)		4b. City, Town, or Location of Death District Heights  4c. County of Death Prince Georges						
Funeral Director		5. Social Security Number 6. Sec. 578 38 6167	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth 37, Yerr	9. Bir 929 Ma	thplace (State or Foreign	n
nd how at	Ļ	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation					10d. Inside City Limits	
Marylar 28a-f s ptiffed	Director	Maryland Prince Geo			t Heights					1 ☐ Yes 2 🛣 N	- 1
with the 23a or 2		10e. Street and Number 7606 Martha Street	et		10f. Zip Code 2074	<del></del>		_	Citizen of What Co		
death items	Funeral		12. Was Decedent Ever in U.S Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No		14. Race - Ame	rican Indian,	
3036 urs after ural", or Il Exami	ted by	1 Never Married 2 Married 3 M Widowed 4 Divorced	1 Yes 2 XXNo If Yes, Give Year or Dates.		☐ Yes 2XX No		,		Black, White Specify:	White	
215-( n 72 hore. e. Medice	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Seconday (0-12)		(Give k	ent's Usual Occupa ind of work done d ONOT use retired)		king	16b. I	Kind of Business	Industry	
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Naryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	To E	17. Father's Name (First, Middle, Last)  Leo Isaac Fo	wler			18. Mother's Nan	ne (First, Middle, peth Pear)				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: or other traumatic event, the Medical Examiner must be notified at once.	5 5	19a. Informant's Name/Relationship (Typ Dottie Lazo (Daughte			g Address (Street a <b>Martha Stre</b>					Code)	
imore Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 F	Removal from State	emetery, crem	sition (Name of atory or other place	7	Date (2011	l	_ocation - City or		
Baltim permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Sig sture of Funeral Service Licenses			In Cemetery Name and Addres			Bre Home	ntwood , N	D Nd Alexandria	
<b>a</b> a a <b>a</b> a a	6 6	Jessica C	mororo	1	erry Road,	Clinton, N	D 20/35			AG MICAGIRII IG	
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FVIII Physic this ce	은	1 ☐ Yes 2 XXNo	ospital:	· · · · · · · · · · · · · · · · · · ·	3 DOA Other	4 🗌 Nursing Ho	ome 5 K Resid	dence 6	3 ☐ Other (Speci	fy)	
JIVISION OT all or Attending Phe safter death. I Director: After the din by the funeral	Certificate:	27. Manner of Death  1 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗆 Y		28d. Describe h	now injur	y occurred		
To the Hospital or Attending P within 24 hours after death. If othe Funeral Director, After the completed filled in by the funeral		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stree	et, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
e Hospit 124 hour e Funera	Medical	(Check 2 L Medical Examine	ian: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investig	gation, in my opinior	n, death occurred a	t the time, date a	nd place	and due to the c	ause(s) and manner state	ed.
To th within To th		29b. Signature and title of certifier		95, 40	29c. License D 43276	number		29d. Da	te signed (Month)		$\neg$
NBS		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, Pri	1830P1	875 10	4 Um	m	albor i	M 20772	$\perp$
Stat Registra		31. Date filed (Month, Day, Year)  NAY 2 4 2	and the state of death (Item  A DA  32. Registrar's Signati	ire A	harde		10	V - 1			+
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			For State Registrar		State of Ma	aryland		artment of F <i>tificate of E</i>	lealth and N Death		giene Reg. No.2	1 1	12329	
	Physicia	ın/	Decedent's Name		a M. Nicol	2				2. Date of Dea Month May	ith	01°1′	3. Time of Death	
	Medic Examin	al	4a. Facility Name (if r			.a		4b. City, Town, or	Location of Death	May	4c. County		5:00 PM	
	Ladiiiii		12206 Car				tt City			ward				
	Funeral Director		5. Social Security Nu 191 20 73			e (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl		9. Birth Coun	place (State or Foreign htry) KY	
	ind show at	5	Usual Residence of D 10a. State	Decedent 10b. County		10c. City, To	own or Loc	ation				1	10d. Inside City Limits	
	Maryla 28a-f s otified	Director	MD	Howard		El.	licot	t City					1 🗆 Yes 2 🎦 No	
	ith the	ralD	10e. Street and Num		1 Dood			10f. Zip Code 2104:	2		10g. Citizen of Unit			
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36	after dal", or i	by	1 ☐ Never Marrie 3 🛣 Widowed 4		Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.	No	- 1	Yes 2 No		riiodii, oto.)		ck, White, Whi		
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and (	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (F. John Buzg						18. Mother's Name Sophia		Maiden Sumam nknown			
aryl	hould band Me s mark umatic		19a. Informant's Nar		pe, Print)		19b. Mailin	g Address (Street a	and Number or Rura			State, Zip (	Code)	
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Baltimore, Maryland 21215-0036	Page 1 ament of Page 1 uny or of		1 XBurial 2		Removal from State	cem	otony crom	sition (Name of natory or other place <b>n Mem. G</b>	erd. 5–26	-2011	20c. Location		ille, MD	
Balti	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Fund	eral Service Licens	1 (1/	401044			os of Facility Har Olumbia P				lly FH Inc. MD 21043	
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	cate be executed physician and the burial-transit	l Exa	that initiated events resulting in death) La		Due to (or as a	a consequen	ce of):							
260	cate be physic s the bu	edical			d	-								
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal de	eath 3 🗌	Ectopic pregnand Other (specify)	у			te of deliv	ery Day Year	
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	Hospita 24 hours Funeral sted fillec	Medical	(Check 2	Medical Exami		xamination an	d/or invest	igation, in my opinic	on, death occurred at	the time, date ar	nd place, and du	e to the ca	use(s) and manner stated.	
	To the within 2 To the comple	_	29b. Signature and ti	tle of certifier	e Practioner: To the			29c. License	number		29d. Date signe	d (Month.	Dav. Year)	
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	\$							100 PA	ekway.	308	, Colur	nous	, MD-21065	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maynth 2011 3:49  $A^{M}$ Joseph Proctor Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Park Takoma Montgomery Sex 1 M 2 D F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. Hours 73 Director 579-46-6600 Sept DC Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 72 hours after death with the Maryland Director MD 1★ Yes 2 No Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 9211 Crandall Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar <sup>Specify</sup>Native American 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Self-Employed 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James C. Proctor Margaret Savoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9211 Crandall Road, Lanham, Maryland 20706 Mae Proctor/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 5/31/2011 Resurrection Cemetery Clinton, MD 21. Signature of Funera Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DECURNIUS Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury Physician: The law requires that the death certificate be executed and -trant that initiated events Due to (or as a consequence of): resulting in death) Last burial-RENAL FAILURE physician the burial Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death nse Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) 1 Yes 2 No 9 Unknown the þ signed to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown been signated the second the seco Completed 24a. Was an Were autopsy findings available prior to completion of cause of Jas page 2 autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: After t Hospital or Attending 5 Pending Natural work' 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 Certifying Nurse Practionar To the best of my knowledge, death occurred at the time, the and place, and the to the 29d. Date signed (Month, Day, Year) 05/25/201/ re and title of certifier 29b. Signat 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAWN SAMMM, HD WASHINGTON KOVENTIST BUST, TAKOMA PARK 31. Date filed (Month, Day, Year) MAY 2 6 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 56 Medical 4a. Facility Name (if not institution, give street and number) A
ho au**Examiner** Sounty of Death 4b. City. Town, or Location of Death WHITE MALL 51 GEORGE SUITLAND 521 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) 1 🗆 M 2 🕱 F 9 Months Hours Min. Director VIRGINIA Usual Residence of Decedent show 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sl e notified PriNCE GEORGE SUITLAND 1 Yes 2 A No APT 10f. Zip Code 10g. Citizen of What Country? pe Funeral ral", or items 23a Examiner must be WHITEHALL 4.5. A 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", 3 -Widowed 4 - Divorced Specify: BLACK t of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DomeSTIC HOUSEKeePer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ EARNESI FLORENCE permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) SHITLAND MD 2074 APT 109 5000 LYDIANNA LA 20a. Method of Disposition 20b. Place of Disposition (Name of RIVERDALE CREMATORY 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MASON . Signature of Funeral Service Licensee FUMERAL ST DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each lip. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ue to (or as a consequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death
Unknown Year signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4, Unknown 24b. Were autopsy findings available 24a Was an has autopsy performed prior to completion of cause of death? certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) in 24 hours after ceau.. he Funeral Director: After this ce noleted filled in by the funeral dire 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 26434 death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

MAY 2

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lottie Frances Mayth 28<sup>Day</sup> 2011<sup>Year</sup> Pumphrey 4:30A. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Copper Ridge Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb. 15, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** West Virginia 1□M 27 F Days Hours Min. 216-22-6166 87 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exemples. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Berwyn Heights Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5717 Berwyn Road 20740 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No 2 White 3 Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Solderer Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Lindsay Hendrick Bertha Lambert ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Holtz -Caregiver 5717 Berwyn Road Berwyn Heights, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 6/1/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funer I Service Licentee Borrald VoresBorral Home, PA de 4400 Powder Mill Road Beltsville, Maryland 20705 bown 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure ist only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final) End Stage Dementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician sthe burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔀 No page 2 should Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a Was an autopsy performed? Yes 2 2 No certificate 2 ANO 1 ☐ Yes 1 ☐ Yes 24 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4K Nursing Home 5 Residence 6 Other (Specify, 2 **X**No 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) NUTSE Praction of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the I within 2 29b. Signature and title of centified 29c. License number 29d. Date signed (Month, Day, Year)

10 SW

State Registrar

DHMH 17 Rev 1/2001

Copper Ridge 710 Obrecht Road Sykesville,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carrie Wheeler

Date filed (Month, Day,

JUN 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HELEN MAY RHONE 20<sup>Day</sup>2011 9:00 p Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11704 DECESARIS BLVD MITCHELLVILLE PRINCE GEORGE'S **Funeral** Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X Davs Hours Min. (Month, Day, Director 577-58-7354 WASHINGTON, DC Usual Residence of Decedent 10a. State at 10b. County the Maryland Director 10c. City, Town or Location 10d. Inside City Limits or 28a-f sh notified MD ¹X☐ Yes 2 ☐ No PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number ö ms 23a or must be 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a 11704 DECESARIS BLVD 20721 ral", or items 2 Examiner mus USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Completed 3 Divorced 4 Divorced Specify. BLACK event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 TH PERSONNEL SPECIALIST GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LEE A TEMPLE EVELYN WADDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS P. RHONE JR./HUSBAND 11704 DECESARIS BLVD MITCHELLVILLE, MARYLAND 20721 other 20a. Method of Disposition permit. Page 1 s
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 5/26/2011 LANDOVER, MARYLAND 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Filysician, Onset and Death METASTATIC CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SARCOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last and tra Due to (or as a consequence of): nding physician use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has page 2 autopsy perform certificate 1 Yes 2X No 25. Was case referred to medical Be examiner?
1 Yes 2 No 26. Place of Death (Check only one) Hospital ဂ္ Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) After this the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending injury s after death Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours at To the Funeral D Medical 29a Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 7/2009 1160 VARMUN STREET N.E. #100 WASHINGTON, DC 20017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signatur

JOSEPH QUASH M.D.

MAY 2 B 2011

31. Date filed (Month, Day, Year

MAY 24, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Month Physician/ PM Inara Antonia Sturans 8:30 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month. Day, 1 □ M 2 🕱 F 578-44**-**8205 78 Stameriene, Latvia **Director** 1933 February Usual Residence of Decedent 10b. County 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Prince George's Bladensburg Maryland 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral USA 20710 5201 Quincy Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ner than "natural", ∢ t, the Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Accountant 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental h Important: If item 27 is marked way injury or Attack and Mental F 0 Edgar Peter Ozolins Livija Staune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zigrida Fogelis / Sister 1800 Bel Air Road, Woodbridge, VA 22191 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rock Creek Cemetery 5/31/2011 Washington, D.C. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death days Immediate Cause (Final Physician/ Anoxic Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Acute Intracranial Hemorrhage days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examin Acute Cerebrovascular Accident days physician sthe buria Physician/Medical Chronic Atrial Fibrillation years Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Hyperlipidemia, Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Acute Respiratory Failure 24a. Was an autopsy performe 2 X No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၀ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 🔀 Natural 5  $\square$  Pending work?
1 Yes 2 No Investigation safter death Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound To the Funer completed file 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year,

State Registrar

Ravinder K. Rustagi, 6132 Landover Road, Cheverly, MD 20785

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAY 2 7 2011

D24720

5/24/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 11:10 P Physician/ May Otis 2011 Shealy 18, Medical 4a. Facility Name (if not institution, give street and number) Ctr. 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Kensington Nursing & Rehabilitation Kensington 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 251-18-4849 0370271922 SC Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County Director ms 23a or 28a-f s must be notified Kensington Md Montgomery 1 🏋 Yes 2 □ No 10e. Street and Number 3000 McComas Ave 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20895 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ıral", or iten Examiner r Black, White, etc. þ 1. Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3X Widowed 4 □ Divorced Black Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 5th College (1-4 or 5+) Construction Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sam Shealv Lillybell Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 750 Gates Ave, Apt. #4B, Brooklyn, NY 11221 Shirley Jones/Niece 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or otl once, cemetery, crematory or other place) 1 🗌 Burial 2 🖾 Cremation 3 🔲 Bemoval from State Riverdale Park Crematory 5/26/11 Riverdale, MD 22. Name and Address of Facility Pope Funeral Homes, F.A. 4 Donation 5 Other (Specify of Funeral Service 5538 Marlboro Pike, Forestville, MD 20746 23a. Part T. Ener the disease, of complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) \_Medical Examiner unknow Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 14 pertension 1 Yes 2 No 3 Probably 4 Unknown been Chronic anemia Peripheral Vascular disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 Yes 2 No Yes **Director:** After this certificd in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Privithin 24 hours after death.

To the Funeral Director; After it completed filled in by the funeral 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred atural injury work 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) rowde 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mn; 15216 Dino Drin Burtonsville, MD20866,

Registrar DHMH 17 Rev 7/2009 CHOWD

NURUL

MAY 2 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 18396 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert Lee Scott Medical May 2011 8:55 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u>Genesis HealthCare</u> The Pines Talbot Easton . Age (In yrs. last birthday)
70 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months August 18<sup>(Month, Day</sup>1 (8<sup>ar)</sup> 1940 Mary Land **Director** 221-26-2454 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Talbot Easton 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29242 West Kennedy Street 21601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, ģ 1 Never Married 2 Married Black. White, etc. Albert Scott Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. 1 Tes 2 No Specify. Completed 3 Widowed 4 Divorced Specify:White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Residential Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard Scott Bessie V. Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Randy Scott/son 29242 West Kennedy Street, Easton, Maryland 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery June 3 2011 Greensboro, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility and Helfenbein Funeral Home, P.A. x 160, Greensboro, Maryland, 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Adult Failure to Thrive Medical Examiner phagia Securitistic list excellibles Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury <u>Advanced</u> ending physician and use as the burial-tran that initiated events resulting in death) Last Physician/Medical Parkinsons death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Live Birth 2 Fetal dea
Pregnant at time of death been signed by the atte should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CVA, Non ST Equation MI should k 1 Yes 2 No 3 Probably 4 Unknown COPD, Depression 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident
Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) NurePrachtone Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) R162359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Maryland /207201 Path of Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SWANN 20.15,0 Awrence Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. Date of Birth Funeral Age (In yrs. last birthday) 9. Birthplace State or Foreign 1 M 2 - F Days Min. Hours (Month, Day, Year Director 6568 Maryland Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f Pleasant Maryland 1 Yes 2 No 10e. Street and Number ö ms 23a or must be r 10g. Citizen of What Country? Funeral 6306 USA 20743 items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. "natural", 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Genge Prince Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Custodi 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Swann Juhn Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sugan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mi) linton 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20648 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Onset and Death disease or condition 1 Medical resulting in death) consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and I-transit Cause (Disease or iinjury that initiated events resulting in death) Last -burialattending physician for use as the buria Physician/Medical mmobilit requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕮 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy Hospital or Attending Physician: The perform this certificate Yes 2 1 No 2 🗆 No 1 TYPS funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ဳ Natural 5  $\square$  Pending injury work? Accident Suicide 2 🗌 No hin 24 hours after deatl the Funeral Director: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month. Dav. Year) 20 -30. Name and addre

State Registrar

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iailes Stewart		- For State	ale of Mary	and / D	Certifica	ate of l	Death	ana		y.		eg. No.	201	18398
Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)					-		- 7	2. Date of Dea	th		3. Time of Death
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Funeral	П	5. Social Security Number	6. Sex	7. Age (In	yrs. last birt	hday)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of Bi	•	Forei	
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Be	19a. Informant's Name/Relations			19	b. Mailing	Address	(Street a			ural Route Nu			e, Zip Code)
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one) 2 Medical Ex.	Physician: To the basiner: On the basi	est of my kr	nowledge, de	eath occurr	ed at the	ime, dat	te and pla	ce, and	due to the car	use(s) and	manner as st	ated. the cause(s)
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2		30. Name and address of perso Jack Titus MD. De	n who completed ca puty Chief Med	ause of deat dical Exa	n (Item 23a) miner 9	900 W. E	Baltimor	e Stre	et, Balti	imore.	MD 2122	3		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8399 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 29, 2011 **Physician** 1:05 PM <sup>M</sup> Sturtz Althea Fern /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Grantsville Goodwill Mennonite Nursing Home Birthplace (State or Foreign Country)
 PA 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year **Funeral** Days 1 ☐ M 2 ☐ F Dec 1, 1923 Director 220-16-6248 87 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at Grantsville MD Garrett 1 ☐ Yes 2 ☐ No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 milluly or other traumatic event, the Medical Examiner must be record. 21536 USA 891 Dorsey Hotel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify 3 Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Grocery Store** 12 Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera (Petenbrink) Murray Irvin Murray ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Wayne Sturtz 13301 Winchester Road SW Cumberland MD 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Cooks Cemetery 6/3/2011 PA Wellersburg 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA fignature of Funeral S 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequ of ce of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has li rector, page 2 s autopsy performed? Yes 2 No 1∐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🏗 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30/ who completed cause of death (Item 23a) (Type, Print) Ave

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 24, <sup>□</sup>2⁄2011 8:25 A M James Louis Tunstall Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral XX**M 2 □ F Months Days Hours Min. (Month, Day, Year) 06/04/1939 **Director** Virginia 71 <u>228–48–3137</u> 28a-f shov 10b. County 10a. State with the Maryland ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Capitol Heights MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 USA 1111 Curled Oaks Place Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ð 1 Never Married 2 Married ☐ Yes X☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Black Completed 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Private Labor 3rd Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Nannie Baptist Williams Tunstall of Health and M item 27 is ma other traumar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 40th Place; Brentwood, MD 20722 James Tunstall - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. jo l 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 5/28/2011 Washington, DC Glenwood Cemetery 21. Signature of Funeral Service Lidenses 22. Name and Address of Facility Freeman Funeral Services 20748 4594 Beech Road; Temple Hills, MD Part . Enter the disease, or o shook, or heart failure. List on omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Metastatic Prostate Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events tran Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 the attending phase to IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12months?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been significant 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛛 Other (Specify) Hospice Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? I Director: After to in by the funeral 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 05-24-2011 D37142 s of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Coleman,

MD 6001 Muncasper Mill Road; Rockville, MD

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Vital

of

Division

31. Date filed (Month, Day, Year)
MAY 2 7 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First\_Middle, Last) 2. Date of Death Physician/ Month Medical Name (if not institution, gilve Examiner Horal Surnie Hune NO 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 🗷 M 2 🗆 F Director Usual Residence of Decedent or 28a-f show s notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and tif fiew 27.5 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at ury or orther traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code Citizen of What Country? "natural", or items 23a o Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black White, etc. þ 1 Never Married 2 Married 2 🗷 No 1 Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 KYes 2 □ No Completed 3 Widowed 4 Divorced alvador 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) abor Be 18.\_Mother's Name (First, Middle, Majden Surname ည Zano forma "'s Name/Rela tionship (Type, Print) (brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 28 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility xxv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Deat Immediate Cause (Final carcinoma Ph\_sician/ stric disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 completed filled in by the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has I autopsy performed? Yes 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XNo Other: 1 🗌 Yes Certificate: To Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Barbara J. Thomas 1.5 2011 May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchestel Cambridge Dorchester General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 19,1941 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗙 F 70 Florida 219-56-8389 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State "natural", or items 23a or 28a-f show 1 □Yes 2 No East New Market Dorchester Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21631 5648 Thompsontown Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☑No Specify Specify: 3 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Dorchester Dept. of is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Wordk Opportunity Case Manager II and 2 should be filed withi lealth and Mental Hygiene. Social Services G.E.D. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Lee Peaton Thomas Mincey, Sr. ျ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5648 Thompsontown Rd., East New Mkt., Vivian L. Thomas/ Daughter Health a other 1 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ÷ per mit. Pages
De, artment of
Important: If it
any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Maryland Eastern Sh. Veterans Cem. 5/23/11 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Christine M. Coale 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HOURS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? o 4 ☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 HInknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed2 page 1 Yes 2 W certificate the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XX 2 ER/Outpatient 3 DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending of Euneral Director: Affoliately filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the F 29d. Date signed (Mgnth, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 NARR 01 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 18 Registrar DHMH 17 Rev 1/2001

2510

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 Day 23 Lhomas 1800 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Grace Hospita Harre de If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. DEC 1 Day, Year) SOUTH CAROLINA 91 Director 241-22-0376 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 ☐ No MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a ( must be Funeral 415 S. MARKET STREET 21078 UNITED STATES items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 ☐ Yes 2 X No If Yes, Give ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify BLACK Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) MINER COAL MINE Be Important: If item 27 is marked on any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ CLARENCE THOMAS COARLEE MCLAURN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK CARROLL / GUARDIAN 145 N. HICKORY AVENUE, BEL AIR, MARYLAND 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BERKLEY CÉMETERY 05/31/11 DARLINGTON, MARYLAND 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 552 LEWIS STREET, HAVRE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Sertic Shock Pnysician Medical resulting in death) (or as a consequence of) Examiner winam tract infection daus Sequentially list conditions, Examine day, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown 9 Unknown rate nas been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☑ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accider
☐ Suicide Investigation 6 Could not be Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

29b. Signature and title of certif

Julie Fiter

South Union Ave Harrede Grace, MD 21078

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

31. Date filed (Month, Day, Year) 32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 02, 201 Par 5:40M Harrison Warnick Timney Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** , Day, Year) May 16, 1912 Days Country) Maryland 1 🗷 M 2 🗆 F Hours 214-07-6227 Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County filed within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 No Lonaconing Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 57 Jackson Street 21539 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 □ No If Yes, Give Black, White, etc. Completed by 1.X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fiber Laborer 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Hettie Warnick John Timney permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22416 Seldom Seen Road, Lonaconing, Maryland, 21539 Gary Cooper 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date June 06. Burial 2 Cremation 3 Removal from State Laurel Hill Cemetery Moscow Mills, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final rocardial Infarction Physician. disease or condition hours Medical resulting in death) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): attending physician for use as the hurial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Africal fibrillation: Peripheral page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Vascales disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 No 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier AD7916072 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 20

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Douglas

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Date filed (Month, Day, Year)

JUN 0 9 2011

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Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last	1)					2	2. Date of Dea Month		Year	3. Time of Death
Medical Examin		Thomas Truman Us:						110-15	May 27, 2	2011	c. County of Dea	2220 hrs
		4a. Facility Name (if not institution, give Hobbs Road	street and number)			4b. City, Town, or Denton	Location	of Death		- 1	Caroline	401
Funeral		Social Security Number 6. Se	x 7. Age	(In yrs. I	ast birthday)	If Under 1 Year	r If Und		8. Date of Bi	rth(MM	/DD/YYYY) g. E	Birthplace (State or
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<b>b</b>	ļ	Usual Residence of Decedent  10a, State  10b, County	11	Oc. City	Town or Locat	ion						10d. Inside City Limits
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Maryland 28a-f show		Maryland   Caroline  10e. Street and Number		ютая	sboro	10f. Zip Code			1	0g. Cit	izen of What Co	21
the M		15121 Jarrell Ro	ad			21636			1	USA		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other transmatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3	Removal from State	,	crematory or oth	ner place)						
ltim it. Pag rtment rtment y or o	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service License		Gre	22 N	O Cemeter	of Facilit	tv				o, Maryland
Depa Department	1	March	ly		F10 PO	eegle and Box 160	d He	lfenb eensb	ein Fu	ner ary	al Home Land 2	1639 <sup>A</sup> ··
Physician	7	23a, Part I. Enter the disease, or complete failure. List only one cause on ear		e death.	. Do not enter th	ne mode of dying,	such as	cardiac or r	espiratory arr	est, sho	ock, or heart	Approximate Interval Between Onset and
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of Vital Records, P.O. Box ing Physician: The law requires that the death After this certificate has been signed by the atteruncial director, page 2 should be detached for un		Part II. Other significant conditions	contributing to death b	ut not re	esulting in the u	nderlying cause g	iven in P	art I.	23e, Did to	bacco	use contribute to	o the cause of death?
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Division of Vital  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif completely filled in by the funeral director.	ल्	(Check only 1 Certifying Physicia	n: To the best of my k On the basis of examin									
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		30. Name and address of person who c				Politime and Ot	roct D	) altima =	MD 2422			
	to I		sistant Medical E			. parumore St	reel, B	ашпоге	., IVID 2122			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 14804 Ashford Court Laurel Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√F Days Months Min. (Month, Day, Year) Hours 56 578-78-6109 Yrs Director North 03/01/1955 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director PG Adelphi MD 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or Funeral 20783 USA 1836 Metzerott Road #511 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No "natural", or þ 1x Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: If Yes. Give Specify:Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BA Automation Clerk US Postal Service permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Shirley Downs Howard Lee Wilder, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9211 Appleford Circle #335; Owings Mills, MD LeAndra Wilder - Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State 6/1/2011 Suitland, Maryland 4 Donation 5 Other (Specify) Lincoln MEM. Cem. 22. Name and Address of Facility Freeman Funeral Services 21. Signature f Funeral Service Licens 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1. Enter the disease, or composhock, or leart failure. List only or cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or comp Approximate Interval Between Onset and Death cause on each line Immediate Cause (Final disease or condition Physician Ovarian Cancer Medical resulting in death) Due to (or as a consequence of) Examiner metastatic to brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 . use a IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an s certificate has b director, page 2 s prior to completion of cause of death? autopsy performed? 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Day, Year) 29b. Signature and title of D0068056 death (Item 23a) (Type, Print) 30. Name and address of person who come 1221 Mercantile Lane Zabeth K 31. Date filed (Month, State Registrar

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Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death v if Health and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu		19a. Informant's Name/Relationship	(Type, Print) PER	SONAL	19b. Mailir							n, State, Zip (	
re, N	and 2: Health tem 27		BONNIE L. WHEET  20a. Method of Disposition	ER, REPRES		YE 75 ace of Dispo			HIL		NE, EA		MD 21 on - City or To	.601
nor.	age 1 ant of 1 tt. If it.		1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Sp	Removal from St	ate ce	emetery, cren	natory or oth	er place)	ADIZ I	Da <sup>*</sup> 5/26				RYLAND
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89 >	oertif anding use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	me of pregnan	ncy death 3 [	Ectopic pr	anancv				23d.	Date of deliv	ery
Вох	death he ath	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of de		Other (spe						Month	Day Year
P.O.	requires that the der been signed by the should be detached	Completed by Physician/Med	Part II. Other significant condition	s contributing to deat	th but not resu	ılting in the u	nderlying ca	use given	n in Part I.		23e. Did to	bacco use c	ontribute to the	he cause of death?
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ord	w require s been si s should	plete									24a. Was a	an 24	lb. Were auto	psy findings available impletion of cause of
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Division of Vital Records,	or Atte fter de irecto n by tl	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of	Injury - At honetc. (Specify)		et, factory,	office		28	f. Location (S City or Tow		mber or Rura	l Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  within 24 hours after death.  complete Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	cal C	29a. Certifier 1 Certifying F	hysician: To the best	of my knowle	vdge death o	occured at th	e time da	ate and pla	ace and	due to the car	use(s) and ma	anner as state	ed.
	ie Hos n 24 h ie Fun oleted	Medical	(Check 2 Medical Ex	aminer: On the basis of	of examination	and/or invest	tigation, in my	opinion,	death occi	urred at th	e time, date a	nd place, and	due to the ca	use(s) and manner stated
	Vithii To th		29b. Signature and title of certifier	MUM	2110		29c. l	icense ni	umber	7.7		29d. Date sig	ned (Month,	Day, Year)
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	2+VA		30. Name and address of person w	OLEY MID	610	DUT	Print) CHM A	NS 1	LANL	٤	EAST	on, Tr	117 6	21601
	Sta Registra		31. Date filed (Month, Day, Year)  MAY 20 201		strar's Signatu	Jan.	U					•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Jun 2 2011 3:04 PM Physician/ Walters Rebecca Ula Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rawlings Allegany 18028 McMullen Highway 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpia-Country) WV **Funeral** Days Hours Feb 7 1 □ M 2 □,F 215-14-6238 90 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.

Important: If fired 27 is marked other than "nature."

any injury or other trees. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Rawlings Allegany 1 XYes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21557 18028 McMullen Highway Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) head cashier 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Etta (Rumer) Evans Andrew R. Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) MD 21557 18028 McMullen Highway Rawlings Jo Etta Simpson niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State MD 6/6/2011 LaVale 4 Domation 5 Other (Specify) 21. Si mature Funeral Servi 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par/1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ eas Medical resulting in death) Due to (or as a consequence of): Examiner astati Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No ☐ Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check 29c. License number 29b. Signature and title of certifie -0056080 ogn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trans 11204 Mamullan SOM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 9 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Andoe DOA M Vincent Rene 201) Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. II, 1954 California 56 **Director** 217-58-4427 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martla Hygiene.

any injury or other transfer. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Anne Arundel Glen Burnie MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 97 Mary Lane #202 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Landscaping 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norman Harding Andoe Pauline Yvonne Lowrev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 97 Mary Lane, Apt. #202, Glen Burnie, MD Rebecca Nay Andoe / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🗌 Burial 2 🔲 Cremation 3 🗀 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 06/08/2011 Bethesda, MD 21. Signature of Funeral Service Ocensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final can con Physician/ con disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) 1 Yes 2 No the a Unknown P.0. been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been a te 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate har ral director, page perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes ပ 1 ➡npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natura.
2 Accident 5 Pending e Funeral Director: A Funeral Director: A selection of the filled in by th Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title 0. Name and address of of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Jeffrev June 6, Farnum Ault 11:47 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5506 Carville Avenue Baltimore Arbutus Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Oct. 22, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours 1950 New Jersey 60 Director 214-56-1017 Yrs. Usual Residence of Decedent 28a-f show 10b. County 10a State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔀 No <u>Maryland</u> Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5506 Carville Ave. 21227 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Collections Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jean Hall Abbott Jessie Louis Ault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Pecksuot Road, North Weymouth, MA 02191 Brandy Ault Petersen / Daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 6-9-11 Towson, Maryland of Funeral Service Ligensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter that isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day as been signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed 1 Tyes Yes 2 N Hospital or Attending Physician: 1 24 hours after death. 25. Was case referred to medical examine?

1 Yes 2 No Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide after death Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature 29c. License numbe person who completed cause of death (Item 23a) (Type, Print)

Year

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 7, 2011 3:40 A M Samuel Joseph Ady Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice @ GBMC Towson Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, May 5, If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours 1934 215-32-3375 **Director** 77 Yrs Maryland May Usual Residence of Decedent 28a-f shov 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 995 Valewood Road 21286 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 ☐ Married 1X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed Specify: 3 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Colonel U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carmelita (unk) Kirby Edward Buckley Adv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marc H. Minkin / Executor 3601 Philips Drive, Baltimore, MD 21208 permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other toonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Hilltop Service Corp.: 6-8-2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licen 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ fancrentic 0-5 omplication's disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending properties as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Petal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (olitis anembranous Division of Vital Records, 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? To the Hospital or Attending Physician: To Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, hours after death.

neral Director: After this illed in by the funeral d 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my called within 24 hound to the second to the fune completed file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien ( 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2 201 AUL BUTLER. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Sinai Hospital of Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**⋤** M 2□ F 82 MD Director 8/19/1928 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination is be notified at once. Yes 2□No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 3451 Cottage Avenue 21215 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 Specify: black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Continental Can Company Machine Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Butler ٩ unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3451 Cottage Avenue Baltimore, MD Clara J. Butler/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/10/2011 Baltimore, MD On-site Crematory 21. Signature of Funeral Service Licensel 22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home West ar Baltimore, MD 21215 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final minutes Physician CALDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier els D 21328 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heights Ave. RATIMONE Mg 21207 4001 Liberry J-Acors 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Butler

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day TIME MARY LOUISE BOWMAN  $20^{\circ}1^{\circ}1$ 6:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 261 BECKENHAM CIRCLE UNIT 201 HARFORD BEL AIR 5. Social Security Number 9. Birthplace (State or Foreign Country) NEBRASKA 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Hours MAY 16, 1928 Days 1 M 2 X Months 508-22-5170 83 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director or 28a-f HARFORD BEL AIR 1 🗌 Yes 2 🛣 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 261 BECKENHAM CIRCLE UNIT 201 21014 USA . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc ŏ Š 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE "natural", 3 Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72 hand Mental Hygiene. (Specify only highest grade completed) 1 2<sup>Elementary/Seconday (0-12)</sup> College (1-4 or 5+) BAR MAID BAR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY H. HESS JOSEPHINE O'GRADY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 show of Health and item 27 is n BONITA DESPER-DAUGHTER MIDDLE RIVER BLISTER ST 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or of SACRED HEART OF JESUS 6/8/11 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMONEK FUNERAL HOME OF BEL AIR 21. Signature of Funeral Service Licensee 610 W. MACPHAIL RD BEL AIR, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final cell down Non Small Physician disease or condition resulting in death) W Medical Due to (or sa considence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for es a consequence off physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown signed to Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autonsv performe certificate 1 🗌 Yes 2 **X**No Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Investigation within 24 hours after deatl

To the Funeral Director:

completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 45530 7-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR 21014 ATWOOD ST, S SAIL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	State Registrar				Ce	rtificate of L	Death		Reg. N	No. 2011	184
n/ al	1. Decedent's Name (F		:t)					2. Date of De Month June		Oay 111 Year	3. Time of Death 12:00A.
er	4a. Facility Name (if no	t institution, give	street and number)			4b. City, Town, o	r Location of Death			c. County of Death	1
	Gilchrist					Tows				Balto.	
	5. Social Security Num 213-34-66	527	ex □ M 2 <b>X</b> F 7. A	ge (In yrs. la 76	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Octobe:	th a <i>y, Year</i> r 27	9. Birth Cou 1934 N	nplace (State or Fore intry) ew York
_	Usual Residence of De 10a. State 10	ob. County		10c Cit	y, Town or Lo	ncation		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Lin
Director	Md.	Balto	•			erry Hall					1 🗆 Yes 2 🔀
al	10e. Street and Number					10f. Zip Code	•		10g. (	Citizen of What Cou	untry?
Funeral	4421 For	ge Road		From to 11.6	3 40	2112		!£\/\/-		USA	
β	11. Marital Status  1  Never Married  3  Widowed 4		12. Was Decedent Armed Forces  1  Yes 2  If Yes, Give Year or Dates.	?		Was Decedent of H If Yes, specify Cuba  1 Yes 2 Xho	an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	-	14. Race - Amer Black, White Specify: Wh	
Completed	(Specify	5. Decedent's E	ade completed)	5.)	(Give	dent's Usual Occup kind of work done of OO NOT use retired)	during most of work	king	16b.	Kind of Business I	ndustry
a)	Elementary/Second 12th 17. Father's Name (Firs		College (1-4 or	5+)	Subs	titute Te	acher 18. Mother's Nam	o (Einst Middle		Education	
၉	Claude W.		e1d					na Durki		n Surname)	
	19a. Informant's Name				19b. Maili	ing Address (Street				or Town State 7in	Code)
	Winfield	S Rawo	r cn	01100		l Forge R					0000/
	20a. Method of Dispos	ition				osition (Name of		Date	20c.	Location - City or 1	Town, State
	1 LXBurial 2 L − 4 Donation 5		Removal from State  v)		ly Hi	matory or other plac $11{ m s}$	6-10-	-2011	$ _{\mathtt{Mi}}$	iddle Riv	er. Md.
	21. Signature of Funera	al Service Licens	ee			2. Name and Addre				uneral H	•
	Bucus	alle	lle			9705 Be	lair r0ad	l Nott	ting	gham, Md.	21236
	23a. Part 1. Enter the shock, or heart fa Immediate Cause (Fin- disease or condition resulting in death)	ailure. List only o	a. Due to (or as	sel	xis	er the mode of dyin	g, such as cardiac	or respiratory ar	rrest,		Approximate Interval Betwee Onset and Deat
Examiner	Sequentially list condi- if any, leading to imme cause. Enter Underlyin Cause (Disease of ingi- that initiated events resulting in death) Las	ediate ng ury	b. Due to (or as							~	
ā			d								
	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ 9 ☐ Unknown	oths?	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 🔲 Feta at time of c	death 3	Cotopic pregnance Other (specify)	Sy			23d. Date of deli	very Day Year
<u>~</u>	Part II. Other significa	nt conditions co	ontributing to death	but not res	ulting in the	underlying cause giv	en in Part 1.	23e. Did t	obacco	use contribute to	the cause of death
g	Swell	GUN	1 065	Vev I	Cro	1		1 🗆	Yes 2	2 No 3 🗆 Fro	obably 4 🗌 Unki
mplet								24a. Was auto perfo		prior to c	opsy findings avail ompletion of cause
ပ္ခံ	25. Was case referred t	o medical				26 DI	ace of Death (Chec.		2/2	No 1 Yes	2 🗌 No
To Be	examiner?	lo	Hospital:	ient 2 🗆	ER/Outpatie	nt 3 DOA Othe			donoo	6 Other (Special	LANSOLLE
	27. Manner of Death  1 Natural 5 2 Accident	☐ Pending	28a. Date of inj (Month, Da	ury	28b. Time o injury	f 28c. Injury work	/ at	28d. Describe h		*	vospi-
Certificate:		Could not be determined				reet, factory, office		28f. Location (S City or Tov		and Number or Rura te)	al Route Number,
Medical	(Check 2   only one) 3	Medical Exami Certifying Nurs	sician: To the best oner: On the basis of the Practioner: To the	examination	and/or inves	tigation, in my opinio death occurred at the	on, death occurred a e time, date and place	t the time, date a	and plac	ce, and due to the ca	ause(s) and manner
	29b. Signature and title	of certifier	lus			29c. License				oate signed (Month,	
	20 Name and address	of person who c	ompleted cause of	death (Item	23a) (Type, I	Print)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month. OB Day Year **Physician** 2:20 Dowman /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Genesis Health Care Hamilton Center Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, **Funeral** Months Days 1 M M 2 □ F Hours 59 25 Mary -58-3819 Director lan 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director More 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 23 llas by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 Specify 3 Widowed 4 Divorced "natural", lack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Potts and C D permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, i 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bo ည wman arson 19a. Informant's Name/Relationship (Type. Print) (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baito. trances Bowma . Pallas MD 2123 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, breenmount Crematory 6/10 4 ☐ Donation 5 ☐ Other (Specify) 21. Si y ature / Fu eral Service Licensee 22 Name and Address of Facility Supply RMS 5 A202 W NOCTH Funeral Homes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hepatocellulas Carcinoma **Physician** /Medical Due to (or as a consequence of): Examiner Ebrovascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the burial-transit law requires that the death certificate be executed 1mmun od Due to (or as a consequence of): attending physician Physician/Medical embou Mmonary for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. been signed by the should be detached 1 Ves 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy ascular performed death? 1 ☐ Yes certificate Protein energy mal Mementa 25. as case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this completely filled in by the funeral 28a. Date of Injury 28h Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? or Attending (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2011 fallsman, ~ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 383 1 308 Eutan . Soulsman, ap 2073 Marcia

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

11-04200	
Edward Burns	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Edward Burns			rtment of Health and Mental F tificate of Death		201	1861
Physicia	_	Registrar  1. Decedent's Name (First, Middle, Last)	mode of Boden	Reg.		3. Time of Death
Medical Exami		Edward Eugene	Burns	June 4, 201		1402 hrs
		4a. Facility Name (if not institution, give street and number)  Bon Secours Hospital	4b. City, Town, or Location of Deat  Baltimore	ın	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las			(MM/DD/YYYY) 9. Birt	hplace (State or
Director		212-48-3772 10M 2DF 61	Yrs. Months Days Hours Min	7-20-		untry) MD
auk	ŀ	Usual Residence of Decedent  10a. State	Town or Location			10d. Inside City Limits
	5	Mb NIA	Baltimore			1 Yes 2 No
ie Maryland or 28a-f show fied at once.	rect	10e. Street and Number	10f. Zip Code	10g	, Citizen of What Cour	ntry?
nith the	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S	3. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Ameri	can Indian, 8lack,
feath w	une	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto		White, etc.	1
s after ral", o	P F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	incerti dono. Id	Specify: B	ack
2 hour		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re			od Nursing
O36 Aithin 7 ene.	Completed	10 0	Laborer	9	Reneb	leater
21215-0036  Join with the Maryland Mental Hygiene.  marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	Be Co	17. Father's Name (First, Middle, Last)	18.Mother's Nam	ne (First, Middle, Ma	aiden Surname)	Sanddia
2 2 2 2		19a. Informant's Name/Relationship (Type, Print) (Brother)	19b. Mailing Address (Street and Number of	Rural Route Number	er, City or Town, State	Zip Code) 21216
MD and 2 sho alth and alth and are 27 in a mumat		Mr. Ned Bobinson Sc.	ace of Disposition (Name of cemetery,	Park Av.	e. Balta 20c. Location - City or	. M.D
Ore, ges lant of He t of He t of ster	m		rematory or other place)	Date 1		
Baltimore, permit. Pages I as Department of He Important: If ite		4 Dopetion 5 Other Specify: 21. Signature of Funeral Service Licerisee	22. Name and Address of Facility	11/2011	Woodland Hom	un Mo
E De De B		Cayseen Gray	272 Feb. Victory	AUL. Ba	1 tz . M.C	21216
Physician /Medical		23a. P nt I. Ey in the discusse, or complications that caused the death. If filtere, list only one cause on each line.			t, shock, of heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Cocaine Alcoho  Due to (or as a consequence of)	1, and Morphine Intoxic	cation		
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)				
	Examine	cause. Enter Underlying Cause				
uted id ansit	Exa	events resulting in death) Last  Due to (or as a consequence of).  d.				
O, e be executed ysician and burial - transi	edical	■ AMENDED 23a,27,2	8a-f,per me,g916 6-17-	-11 sm		
3760, ificate be g physic s the burn		IF FEMALE: 23c. If yes, outcome of pregnation the 23c. If yes, outcome of pregnation the 1 Live birth	ancy 2 Fetal death 3 Ectopic pregr	nancv	23d, Date of delivery Month	y Day Year
Box 6876 e death certificat the attending phy- ied for use as the	Physician/N	past 12 months?  4 Pregnant at time of dear	2			
ords, P.O. Box 6876  w requires that the death certificat s been signed by the attending ph should be detached for use as the		Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
P.O.	ē ē			1 Yes	2 No 3 Prob	oably 4 🗹 Unknown
ords w requi	Completed			24a. Was an autopsy	prior to o	topsy findings available completion of cause of
Rec( The laricate ha	E			perform 1 ✓ Yes 2		es 2 No
Vital Recc ysician: The lav his certificate ha director, page 2	B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 V	26 Place of Death (Check ER/Outpatient 3 DOA Other Nursi	only one)	esidence 6 Other	
Of V ing Phys After thi	2	1 V 163 2 140	28b. Time of Injury 28c. Injury at Work?	28d. Describe ho		
ion ttendir death.	atio	Pending Investigation Fd 6-4-11	fd 1:29 pm 1 Yes 2 X No	Unknown		
Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the contractors.	Certification:	Suicide Could not be determined (Specify) Postido	me, farm, street, factory, office building, etc.		te)1439 Mount e,Md.	ral Route Number, City  Moore Ct.
bou hou		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, an	d due to the cause(	s) and manner as state	ed.
To the Hospi within 24 hou To the Fune completely fi	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.				
	≥	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed <i>(Moi</i> <b>June 5, 2011</b>	nn, Day. (eat)
38	-	30. Name and I dress of Lerson who completed cause of death (Item 2				
a les		Pamela E. Southall, MD Assistant Medical Exam	niner 900 W. Saltimore Street, Balt	timore, MD 212	223	
	ate rar	31. Date filed (Month, Day, Year) 32. Kegistrar's Signatur	- parked			

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day CHARLES WILLIAM BAER 2011 JUNE 40P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverview Rehab & Health Center Raltimore 7. Age (In yrs. last birthdav) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** (Month, Day, Sept. ] XX M 2 D F Months Davs Hours Min. 212~07~6413 **Director** 90 Marvland Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Marvland Baltimore 28a-f Baltimore County 1 ☐ Yes 🗶 🛣 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 9547 Shirewood Ct. 21237 USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates. WW11 Specify: White "natural" Completed **X** ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rthan t tthe № Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12th grade N/A Policeman Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Unknown Hannah Debeer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 9547 Shirewood Ct. Baltimore, Md. 21237 Darlene Smith (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once, XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Faith 6-9-2011 Gardens Baltimore, Md. re of Funeral Servige Licensee 22. Name and Address of Facility
Lassahn Funeral Home Belair Rd. Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementa Ph, sician/ disease or condition resulting in death) -Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 Hospital or Attending Physician; The law requires that the death certificate I 24 hours after death.

Funeral Director: After this certificate has been signed by the attending phys IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by SCVD 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performed Yes 2 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: ျှ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No the f Accident Investigation 3 Suicide 4 Homicide To the Hospital or Atter within 24 hours after des To the Funeral Director completed filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal Projacot 8813 Worthow Woods Parkville MD 21234 Rd 8813 apati Vai 31. Date filed (Month, Day, Year) State 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 005 AM Braswe1 eith 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wash If Under 24 Hrs. If Under TYear 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) tate or Foreigr unk **Funeral** Hours Months Days 1∏M 2□F Dec 23, 1945 65 Director 237-68-0721 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at aprese. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 ☐ Yes 2 ☐ No Director MD Hagerstown Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 14014 Marsh Pike USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) automotive mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Colene Suddrech Robert Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Colene Saunders/mother 234 Locust Avenue Hampton, VA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Similar of Euneral Service Libensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caure (Final rebrovasc **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directs for an a consecutions off Examine To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: ate has been signed by the attendin page 2 should be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No this certificate after death.

Director: After this certifical in by the funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

401

32. Registrar's Signature

To a string g To a string g To a string g		For State	State of Maryland /		ment of H		nd Me		giene Reg. No:()		10100
Physicia		1. Decedent's Name (First, Middle, Last Frank Francis Bun	,				2	2. Date of Dea	ath -	. <del>U    </del> 8, 2ීටී1:	3. Time of Death 9:30F M
Medi Examir		4a. Facility Name (if not institution, give: Saint Joseph	Medical Cente		o. City, Town, or		Death WS OT		4c. C	County of Death Balti	more
Funeral Director			7. Age (In yrs. last b		f Under 1 Year lonths Days	If Under 2 Hours	4 Hrs. 8	B. Date of Birt Sept. 0	հ Ց <b>,</b> 192	9. Birt <b>2 Joh</b>	nplace (State or Foreign
aryland a-f show fied at	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		wn or Location	on			<u>-</u> -			10d. Inside City Limits 1 ☐ Yes 2 No
with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 602 Goucher Blvd.			10f. Zip Code	21286			10g. Citize	en of What Co	untry? States
re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.  The stream 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1- Yes 2 No If Yes, Give Year or Dates. W.W.II		Decedent of Hises, specify Cubar		in? (Specii Puerto Ri	fy Yes or No- can, etc.)		4. Race - Ame Black, White pecify:	
Baltimore, Maryland 21215-0036 permit Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam price.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)		(Give king	t's Usual Occupa d of work done d IOT use retired) Postal	urina most i	of working	3		d of Business  Post	al Service
rland Z I be filed w Mental Hyg irked othe tic event,	To Be	17. Father's Name (First, Middle, Last)  Michael Bunja				18. Mother	r's Name ( <b>Huny</b>	First, Middle,	Maiden Su	ırname)	
, Maryl id 2 should leath and Me n 27 is marl er traumati	(3)	19a. Informant's Name/Relationship (Ty Mrs.Catherine F.B	pe, Print) unja (wife)	9b. Mailing A 602 G	Address (Street a	and Number 3 <b>lvd.</b>	or Rural f	Route Number	r, City or To <b>Mary</b> ]	own, State, Zig Land 2	1286
		20a. Method of Disposition 1 ☐ Burial 2 H Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	atrion Se	pry crether lace	r. IJ	Saturd ine 11	1,2011	Fore	st Hil	Councy) 1,Maryland
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens	THE WELLOW	در الم	S YOK H	OELI	THICL	muliprenty	(TELL	<b>ration 0</b> 21093-2	enter, P.A. 215
Physician/ Medical		23a. Cirt (Englishe disease), or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ilications that caused the death. Due cause on each line. a. SEFSIS  Due to (or as a consequence		ne mode of dying	g, such as c	ardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to immediate	b. PNEUMONIA  Due to (or as a consequence	ce of):							2 DAYS
760 cate be executed physician and sthe burial-transit	lical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. CHRONIC OF  Due to (or as a consequence)		CTIVE F	PULMO	<u>INARY</u>	/ DISE	ASE		10 YEARS
Box 68° death certification and for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1  Live Birth 2 Fetal de 4  Pregnant at time of deat 9  Unknown	eath 3 🗌 🖯	ctopic pregnanc other (specify)	y 			2	3d. Date of de Month	livery Day Year
S, P.O ires that the signed by d be deta	þ	Part II. Other significant conditions co	ontributing to death but not resulting	ng in the unde	erlying cause giv	en in Part I.					the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director. After this certificate has been signed by 1 define by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	Completed	CORONARY ART	ERY DISEASE					24a. Was auto perfo		prior to	topsy findings available completion of cause of
fital F sician; T certifica irector, p	Be	25. Was case referred to medical examiner?	Hospital: 1 <b>X</b> Inpatient 2 □ ER/	/0	Othe	ace of Deat		only one)		Other (Spec	
on of V nding Phy ath. r: After this ie funeral d	Certificate: To	27. Manner of Death 1 Manual 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year) 28	b. Time of injury	28c. Injury work	/ at	28	8d. Describe h			ary)
Division tale or Atternate al Directo led in by the		3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street,	, factory, office		2	8f. Location ( City or Tov		Number or Ru	ral Route Number,
To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 Medical Exami	sician: To the best of my knowledg ner: On the basis of examination an se Practioner: To the best of my kn	id/or investiga	ation, in my opinic ath occurred at the	on, death oc e time, date	curred at t	he time, date a	and place, ne cause(s)	and due to the and manner as	cause(s) and manner stated stated.
14.		29b. Signature and title of certifier	MD		29c. License	onumber 00597	11			signed (Mont	•
10, 24	te_	Od Data Stad Month Day Voorl	M.D. 7601 OSL	ER DE	RIVE T	owso	N, M	ARYLAI	ND	21204	
Regist	ar	JUN 1 0 20	32. Height far's Signature	par	K)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Katherine Mildred Bailey June 8 Day 201 Year Physician/ 6:40 P Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville 2420 Perring Woods Road If Under If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year **Funeral** Month, Day Ye Year 919 Months Days 1 M 2 TYP Maryland 215-18-2632 Vrs Director Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director Parkville Baltimore MD 1 ☐ Yes 2 🔀 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 2420 PerringWoods Road USA or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Specify. "natural", 3 Widowed 4 XDivorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Foreman than " Koppers Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 10 Be 18. Mother's Name (First, Middle, Maiden Surname)
Ida V. Davis 17. Father's Name (First, Middle, Last) ၀ Edward A. Shelley permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2334 Searles Road–Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Betty Smearman-niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place.
Gardens, of Faith
Cemetery June 11,2011 1 X Burial 2 Cremation 3 Removal from State Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral 8800 Harford 21. Signature of Funeral Service Licensee and Cremation Ser. kville, Maryland 21234 Chapel and Road-Parkvi Evans 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on eart Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consiguence of) Exami burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ō Year Month Day Pregnant at time of death Yes cate has been signed by the a page 2 should be detached f 9 Hinknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital Other: 1 Yes 2 X No 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Costifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) Signature and title of c 29c. License number 2qh 9. 2011 he completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 12 MD

DHMH 17 Rev 7/2009

State Registrar Day, Year)

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Harold Herman Certificate of Death 1. Decedent's Name (First; Middle, Last) 2. Date of Death 3. Time of Death 20 l 0250 AM Physician/ Betsworth Tune tarold Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil VA MARYLAND HEALTH CARE SYSTEM PERRY Poin+ | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | Mar. | 6, 1921 9 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Iowa Months 1 💀 M 2 🗆 F 483-48-2802 90 Betswirth Director Usual Residence of Decedent show 10d Inside City Limits 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🄀 No Marvland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21040 USA 636 Hornbeam Road "natural", or items to physician! 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. , or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes Give Specify Completed 3 X Widowed 4 ☐ Divorced White Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Mechanic U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ot any injury or other traumatic even THO EN Dorothy Johanna Elsen ည Harold Dewey Betsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 900 Waters Ave., Fallston, Maryland 21047 Dorothy L. Moore / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-14-2011 Bel Air, Maryland Mt. Carmel U.M. Cem. | 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Plu ician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to for as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transi that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Other (specify) Pregnant at time of death Yes 2 No signed by the a Id be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Inknown Completed page 2 should need 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has performed? Yes 2 No death? 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; p 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: work? (Month, Day, Year) Natural 5 Pending M 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie MOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. O. VA MARY land Health Care System, Perry Point, MD 21902 MAddox 13A 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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To the Ho within 24 To the Fu completely	Med	29b. Signature and		and mar	nner stated					se number				ate signed (Mo	
		1		11-1.	2	Y A			O.C.	M.E.	001	WE	June	8, 2011	
	-	30. Name and add	ress of perso	n who completed	d cause of	death (Item 2	3a)								
		Theodore N	•			/ledical Ex		900 W.	Baltir	nore Str	eet, Balt	imore, Mi	2122	23	
Stat	te	31. Date filed (Mor	nth, Day,Year	) [	32. Registr	ar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rosetta Barley 2011 11:43AM /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital N/Aaltimore ames If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 09/28/1942 Social Security 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours Min. Maryland 1 □ M 2 □**X**F Yrs. 217-38-4768 68 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ? is marked other than "natural", or Items 23a or 28a-f show traumatic event, It a Modical Examination in Afficial 1X Yes 2 □ No Director Baltimore MD N/A 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21217 U.S.A. 526 Roberts St. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10th Grade and Mental Hyglene. is marked other than College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If Item 27 is marked oth any lijury or other traumatic eveni once. Be James unk Josephine Boyd ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3406 Copely Rd., Baltimore, MD 21215 Deborah Hope(cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06/11/11 King Mem. Park Baltimore, MD 4 Donation 5 Dother (Specify) Joseph H. Brown Jr. 2140 N. Fulton Ave., 21. Signature of Funeral Service Licensee 23a. Fort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respira /Medical Pulmonary Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Cardiovascular he Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation neral Director: A 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of deal (Item 23a) (Type, Print) 900 S Caton Ave, Baltimore MI) 212 have n 31. Date filed (Month, Day, Year) State

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Registrar

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ì	Funeral Director			M <b>2√CX</b> F 76	Yrs.	Months Days	Hours Min.	JUNE 23	(Year)	MARYLAND	_
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5-0036	iours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 💹 No			Specify	***************************************	_
Maryland 21215-(	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Macified Engineer must be notified at	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired JRSE	during most of work	ing	HOSP	usiness/Industry	
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aryle	d 2 should be th and Menta 7 is marked traumatic ev	မ	WILLIAM RICH  19a. Informant's Name/Relationship (Type		ROHDE 19b. Mailir	ng Address (Street	MARGAR and Number or Rui		r, City or Town,		
2	ss 1 and 2: of Health a item 27 is r other trau		ROBERT COHEN/HUSB.			CAMERON			MD 212		
nore	ages 1 nt of H t: If iter / or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	movai irom State		sition (Name of natory or other place	i			City or Town, State	
altimore,	permit. Pages 1 Department of 1 Important: If ite any Injury or of once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fungeral Service Licensee		and the second second	CREMATOR		1/2011	GLEN B		
m	o a iii o		then &		E .	6415 BE	ELAIR ROAI	) BALTI	MORE M		
	Physician // // // // // // // // // // // // //	:xaminer	23a. Part1. Enter the disease of complication shock, or heart failure list only one immediate Cause (Final disease or condition resulting in death)  Scounting y list could be if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	infan	dion			Interval Between Onset and Death	5
.O. Box 68760	The law requires that the death certificate be exate has been signed by the attending physician bage 2 should be detached for use as the burial	Physician/Medical E	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. If yes, outcome of pre- 1  Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregnand □Other (specify) _	ру			ate of delivery onth Day Year	
rds, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions control Www.NAMY TVCC	ibuting to death but not in the control of the cont	resulting in the u	nderlying cause giv	ven in Part I.			tribute to the cause of death? 3 ☐ Probably 4 ☐ Unknowr	n
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f Vital	nysiclan	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2	: ☐ ER/Outpatier	nt 3 □ DOA Oth	26. Place of Deat ner: 4 \sum Nursing Ho	ome 5 ☐ Resid		her (Specify)	
0 0	iding Phys th. After this funeral dir	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year	28b. Time o Injury	Wor	ryat rk? ]Yes 2 □No	28d. Describe h	ow injury occur	rred	
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)		1100 2 2 100	28f. Location (S City or Tow	Street and Numb In, State)	ber or Rural Route Number,	
	ne Hospit n 24 hours ne Funera	Medical (		cian: To the best of my er: On the basis of examand manner stated.						nanner as stated. and due to the cause(s)	
	To the confidence of the confi	M	29b. Signature and title of de tifler	MD/res	dent	29c. Licens	se number		6/8/	ed (Month, Day, Year)	_
	3		NARghz Muga	Nlinska	Item 23a) (Type,	Print) O DOD	Frankli	N Sque	ne B	a Baltimora	e
	Sta Registra		31. Date filed Month, Day, Year)	32. Registrar's Sig	arke					14 212	37

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28<sup>Day</sup> 201<sup>Year</sup> **JERVIS** H. COLLINS 4:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN 22 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ፟፟ M 2 □ F WASHINGTON, DC **Director** Yrs. 577-38-4106 82 1929 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1√ Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe items 23a ner must be Funeral 1706 BRIGHTSEAT ROAD # 103 20785 USA 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or ite Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. BLACK Specify: Completed 3 X Widowed 4 Divorced Year or Dates event, the Mudical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH SECURITY GUARD PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ALLEN COLLINS BERNICE HAWKINS traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE R. COLLINS/DGT. 1706 BRIGHTSEAT ROAD #103 HYATTSVILLE, MARYLAND permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other troonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cheltenham Vet. Ceme. 06/15/2011 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock for leart fail re. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) for use as the burial-transil Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) signed by the a P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Inpatient 2 I ပ ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060100 MD DW 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) Vairoit Empl 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 0 2011 Registrar

DHMH 17 Rev 7/2009

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Registrar

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	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No.	3428
Physician Medical Examine		
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4701 Shamrock Avenue 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number un] 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State Foreign Country)	∍ounk
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside	City Limits
Maryland 28a-f show	Baltimore 1 10g Citizen of What Country?	2 No
the Maryland		
fter death with		ilack,
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 77 is marked other than "natural", or items 23a or 28a-fah injury or other traumatic event, the Medical Examiner must be netified at sace TO PRO Completed by Elizabeta Discontant	for Dates:	unk
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MD 21  rd 2 should  rd 2 should  reflect and Me  m 27 is ma.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0.C.M.E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore Street Baltimore, MD 21223	•
IOFE, N ges l and nt of Health i: If item other trau	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State Crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Baltimore, permit. Pages 1 ar permit. Pages 1 ar Important. If files injury or other tr	4 Donation 5 X Other Specify: in state  21. Signature of Funeral Serve Licensee  22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street	t
Physician //Medical	23a. Pank. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Onset and
:xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Morphine Intoxication  Due to (or as a consequence of):	ath
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760, ficate be exe 3 physician a the burial -	☐ AMENDED 23a,27,28a-f,per me,g916 6-13-11 sm  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician Madical Expedical Certification:	23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Day 2 Other (Specify)	Year
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f Vital Rec Physician: The r this certificate ral director, page To Be Con	25. Was case referred to medical examiner?  1  V Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 V Other. Scene	
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Division of No the Hopital or Attending Phy within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:		
F × F ×	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  May 18, 2011	)
	30. Name and address of person who completed caute of death (furn 23a)	
State	e 31. Date filed (Month, Pay Year) 0 2014 32. Registrar's Signature	
Registra	OUT TO COTT DENON B. Marie	

11-04147 Sharon Sue Cox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

haron Sue Cox		1- For State	of Maryland		rtment of tificate of		and	Menta	ıl Hyg		eg. No.	201	1 1842
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Las Sharon Sue C	t)						- 1	Date of Deat Month June 2, 20	th Day	Year	3. Time of Death 1350 hrs
		4a. Facility Name (if not institution, give 8100 Stansbury Road		ər)	14	b. City, Tov		ocation of I		00110 2, 20	4c. Cc	ounty of Dee	
Funeral		5. Social Security Number 6. So	9x 7.7	Age (In yrs. la	ast birthday)	If Under		If Under 2	24Hrs.	8. Date of Bir		ΥΥΥΥ) 9. B	irthplace (State or
Director		212-60-6302 1	M 2XF		59 Yrs.	Months	Days	Hours	Min.	02/0	8/195	Fore	<sup>ign</sup> <sup>ountry)</sup> Maryland
h		Usual Residence of Decedent  10a, State 10b, County		Inc. City	Town or Location	on							10d. Inside City Limits
d how any		MD Baltim	oro		ings Mi								1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number	OLE.	<u>Ow</u>	TINGS MI	10f. Zip C	ode			11	0g. Citizen	of What Co	untry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once		992 Reisterstown				211					U.S.		
ath wit items 2	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decede	s?		s Decedent es, specify (				cify Yes or No- ican, etc.)	- 14.	White, etc.	nican Indian, 81ack,
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iled wi Hygie d other	ပ၂	17. Father's Name (First, Middle, Last)					18	3. Mother's	·	irst, Middle, M	Maiden Sur	name)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	To Be	Clyde Edgar  19a. Informant's Name/Relationship (1	Walters ype, Print)		19b. Mailing	Address	(Street a	Mary and Numbe	er or Ru	Jane ral Route Num	Lieds	r Town, Stat	te, Zip Code)
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ore, es l an of Hea If iter		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from		Place of Disposi crematory or oth		of ceme			Date			or Town, State
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Dem Dem	1. 2	23a. Part I. Enter the disease, or confi							Dr.	Ste.	P, H	anover	MD 21076_
Physician	, ,	failure. List only one cause on ea	ach line.	ed the death.	Do not enter th	e mode of o	dying, sı	uch as card	diac or r	espiratory arre	est, shock,	or heart	Approximate Interval Between Onset and Death
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	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo			al death	3	Ectopic p	regnand	;y		ate of delive	ry Day Year
	Physician/M	past 12 months?  1 Yes 2 No 9 Unknown		at time of de	ath 5 Oth	ner (Specif)	v)						
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Records The law requi icate has been page 2 should	Completed									24a. Was autop			autopsy findings available completion of cause of
		25. Was case referred to medical				26	Place	of Death (C	back on	1 Yes		1 🗸	
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Division tal or Attendi is after death.	catic	2 Accident Investigati	on Jun 2, 2011	1	1339 hrs			es 2 🗸 N		8f Location (S	Street and	Number or F	Rural Route Number, City
Divisi Hospital or At 24 hours after of Funeral Direct stely filled in by	Certification:	3 ✓ Suicide 6 Could not determine	be		,	., .==.,,,				or Town, S 100 Stansbu	tate)		
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To the within To the comp	Medical	one) 2 Medical Examine  29b. Signature and title of certifier	and manner state		Travor III Vooligat		License						onth, Day, Year)
		Pt. () -	P.00.	_			O.C.M	I.E.			June 3	3, 2011	
$\phi$		30. Name and address of person who				000 144 5	حزناه	ore C1	ot Po	ltimere 84	D 24222		
	oto.	Patricia Aronica-Pollak MI		Medical I		900 W. B	saitim	ore Stre	et, Ba	Itimore, M	D 21223	)	
Reaist	ate	31. Pale Nie 1 (Montin Galvi Year)	execute to	The same									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John ne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2338 Pennington Road Re1Air Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last hirthday) **Funeral** Country) st <u>Virginia</u> 1 🗆 M 2 🔀 F Days Hours (Month, Day, Year) 08/24/1926 Director 84 West 234-40-2412 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 K No Harford MD Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21015 2338 Pennington Road U.S.A. and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2 X No Yes, Give p 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accountant Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kelsie M. Ferrel A.K. Hatfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 MD 21015 Sandra McGainey / Daughter Pennington Road, Bel Air, injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State 06/07/2011 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of uneral Service Lice s e 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ cinoma Lav disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a son esqueries of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Day 5 Other (specify) ed by the a g Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ¥ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The after death. 1 ☐ Yes 2 ☐ No 1 L Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 🕱 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? hours after death. neral Director; After the filled in by the funera Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

no completed cause of death (Item 23a) (Type, Print)

32. Regis

			For	Please amend	Type or Pu item 20 State of N	rint in I b per Marylan	Black Ir fn g9 d / Depa	ndelib 1777 artmer	<b>le Ink</b> -15-1 nt of H	<b>Ens</b> l vt lealth	<b>ure A</b> and M	<b>II Copie</b> Iental Hy	s <b>Are</b> giene	e Legik	ole.	101.31	
		•	For State Registrar			Certificate of Death								<u> </u>		10401	
	Physicia	nn/	1. Decedent's Name (First,									2. Date of Death Month June 9, 2011  3. Time of Death 3:51 A					
p. 0.	Medi	cal	Laura Lee			et and number)  4b. City. To				June 9,				2011 3:51 A M			
	4a. Facility Name (If not institution, give street and num.  Hooper House Hospice						in bely			Forest Hill				Harford			
	Funeral Director  5. Social Security Number 212-12-2134  6. Sex 1					7. Age (In yrs. last birthday) . 90 Yrs.			Under 1 Year If Under 24 Hrs. 8. Date of onths Days Hours Min. (Month, Mar.				Birth Day, Year) 27, 1921 Mary I and Mary I and			lace (State or Foreign Tand	
0	D ow		Usual Residence of Deced	10c Cit									0d. Inside City Limits				
	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral Director	Maryland Ha		Edgewood									1 🗆 Yes 2 🎽 No			
		اقِر	10e. Street and Number				10f. Zip Code								g. Citizen of What Country?		
		nera	623 Mulberry Lane				21040						USA  ify Yes or No-  14. Race - American Indian,				
10		by Fu	11. Marital Status  12. Was Decedent Armed Forces?  1 Never Married 2 Married 1 Yes 2			t Ever in U.S ? No	5. 13.	Vas Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.)				city yes or No Rican, etc.)	ı- I	an Indian, etc.			
036		ed b	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.					1 🗌 Yes	Yes 2 No Specify:					Specify: White			
250		Completed	15. Decedent's Education (Specify only highest grade completed)				(Give kind of work done during most of working							6b. Kind of Business Industry			
212		Con	Elementary/Seconday (0-12) College (1-4 or 5+)				) ife. DO NOT use retired) Homemaker						Own Home				
$\mathcal{S}$ ( $\mathcal{S}/q$ $\mathcal{M}$		Be (	17. Father's Name (First, Middle, Last)						18. Mother's Name (First, Middle, Maide								
y sa	uld be Menta narkec	ြိ	Jerome Carvel Struck						Margaret Ola Lich								
Äa'("	2 should th and Me 27 is mar traumati		19a. Informant's Name/Re			Dand								y or Town, State, Zip Code)  Sarvland 21160			
	f Heali item 2										_	c. Location - City or Town, State					
) C Omi	Page nent o ant: If ury or		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Arlington Nat'l Cem. (CPW)  Arlington, Virginia										Virginia_				
9,2011Baltimo	Stephanie Cliffe-Moore / Daughter 1509 Main St., Whiteform 1509 Main St																
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or													<u>n, Ma</u>	ryıa	Approximate	
JUNE	Physician/		shock, or heart failui Immediate Cause (Final	re. List only or	e cause on each line.												
L)	Due to (or as a confequence of):																
	Examiner		Sequentially list conditions, b.														
	ed	Examiner	Sequentially list conditions, if any lending to the elliptic cause. Enter Underlying Cause (Disease or injury)														
	executed an and rial-transit		that initiated events c.  Due to (or as a consequence of):														
W 8		dica			d				_						_		
FF 687	ath certificate be ex attending physician for use as the burial	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy									23d. Date of delivery					
WFFE Box 68760	leath c e atten d for u	siciar	in the past 12 month 1 \(\sum \) Yes 2 \(\sum \) No	tal death 3  Ctopic pregnancy death 5  Other (specify)							Month Day Year						
0.	t the d by the	Completed by Physician/Medical	9 Unknown									23e Did	oid tobacco use contribute to the cause of death?				
7// U.	res that the death signed by the atte	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fact. 23e. Did tobacc											2 No 3 Probably 4 Unknown			
27 ords	v require s been si should b	lete	24a. Was an autopsy										24b. Were autopsy findings available prior to completion of cause of				
3 es	The lav ate has bage 2	I W										per 1 🗆 Ye	rformed?				
ta	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	l a	25. Was case referred to medical 26. Place of Death (Check only one)											befor Ilvici			
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		2	1 Yes 2 No		1 ☐ Inpatient 2 ☐ ER/Outpatie				28c. Injur	4 ⊔ ۱	Nursing Ho	Home 5 Residence 6 Other (Specifical Processing Specifical Process					
o uc		icate	1 Natural 5 2 Accident	Day, Year)	injury	М	work?										
Division of Vital Records,	or Attendi after death. Director: A	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)										on (Street and Number or Rural Route Number, Town, State)				
٥	To the Hospital or within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier (Check (														
	a conty one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 29b. Signature and title of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to be so only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place in the pla									ce, and due to	29d. Date signed (Month, Day, Year)						
	FSFO	1 DAMISSCAND						R149792						6/9/2011			
	30. Name and address of person who completed cause of death (Item 23a) Type, Print)												1 21093				
	V	ote	31. Date filed (Month, Da)	Year)	32 Pag	Strar's Sign	ature.	UNIL	Cy	IALL	c7 K	-1) //	1701	VIUP	<i>i</i> <u>j~l</u>	U 4013	
	Sta Regist	ate rar	JU	N I O 2	011	w	1. 1	arka	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 June 2, 8:27 PMM George W. Donadoni Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Ctr Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Y New York 1 💢 M 2 □ F 80 **Director** 093-24-9119 Nov Usual Residence of Deceder or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2x No MD Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral USA 21061 622 Baylor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married 2 🗆 No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 💢 No Specify: "natural", 3 Widowed 4 Divorced Completed **'**52-56 injury or other traumatic event, the Medical Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) federal goverment 12 executive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or our မ Gertrude Catherine Aman William Donadoni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 Bavlor Road Glen Burnie, MD 2106119a. Informant's Name/Relationship (Type, Print) 622 Baylor Road Glen Burnie, MD Lorraine R. Donadoni/spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗌 Burial 2 🗌 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 X Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Ronald S Walle रिवार and Affat of जिल्ला Board 655 W. Baltimore Street Director 21201 MD Baltimore, 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Qnset and Death -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to or as a consequence of cause. Enter Underlying and -transit Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 LI Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date siggled (Month, Day, Year)

State Registrar 31, Date filed (Month,

7845 PAKWOOD RO SUITE 106 GLENBURNIE

30. Name and aggress of person who completed cause of leath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 8 per fh,g922,12/15/2011dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 636 whe Medical 4b. City, Town, or Location of Deat 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Otimore Greneral HU. 8. Sate of Birth 7. Age *(Ir* yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** 1 SAM 2 □ F Months Davs Hours Min. 05/09/1960 Country) Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director 1 Yes 2 No more 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? Department of Health and Mental Hygiene. Internating it it is a said in inportant: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be a new. Funeral Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 140 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 7No If Yes, Give Year or Dates Specify: 10614 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) The NABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 21 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 21217 Liluar Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse s 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No the a 9 Unknown 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? page 2 No 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospita 1 🗌 Yes 2 No Other: မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending after death. 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 0 eux of

State Registrar 30. Name and address

Date filed (Month, Day,

1 0 2011

23a) (Type, Print)

person who completed cause of death (Item

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 12:45 RM 9 2011 Dzintra Jaunarajs Dungan June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 9. Birthplace (State or Foreign Country Latvia Social Security Number 8. Date of Birth (Month, Day, Dec 18 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 1 🗆 M 2 🔀 Days Min Year) 19<u>23</u> 87 **Director** 153-24-4223 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 No Baltimore Towson 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a Funeral the Medical Examiner must 824 Stags Head Rd 21286 United States or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Specify: Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) n and Mental Hygien 12 Own Home Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Karlis Jaunarajs Valentina Cabelis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Anita Dungan /Daughter 824 Stags Head Rd. Towson, injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Jun 11 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 2011 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01443 any 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oriset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans Due to (or as a consequence of) resulting in death) Last signed by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe Completed 2 No 1 Yes 3 Probably 4 Unknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes : After 28d. Describe how injury occurred Natural 5 Pending injury 2 No the f 2 Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOWYOR MO

Registrar DHMH 17 Rev 7/2009

State

onth, Day, Year)

31. Date filed (Month.

N. Chambs

			Please 1	ype or Print in amend item# State of Maryla	Black Ir	ndelible Ir	nk. Ensure 1916, 6–10-	All Copie:	s Are Legible	
		•	For State Registrar	State of Maryla		tificate of			Reg. No.2011	18435
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Constance Ma	e Dorsey				2. Date of De. June	7 <sup>Day</sup> 201 <sup>Year</sup>	3. Time of Death 1:08 P <sub>M</sub>
Jan. 1	Medic Examin		4a. Facility Name (if not institution, give st			4b. City, Town,	or Location of Death		4c. County of Dea	th
	Funeral		4903 Ridge Road  5. Social Security Number   6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Yea	r If Under 24 Hrs.			thplace (State or Foreign
	Director		099-24-1469 1 Usual Residence of Decedent	M 2X F 80	Yrs.	Months Days	Hours Min.	Jan. 15	7,1931 Nev	v York
	ryland r-f show ied at	Director	10a. State 10b. County MD Baltim		City, Town or Loc	eation sedale				10d. Inside City Limits 1  Yes 2 No
	a or 28a be notif		10e. Street and Number			10f. Zip Code	24227		10g. Citizen of What C	
	ath with sms 23 r must	Funeral	4903 Ridge Road	2. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of	21237	pecify Yes or No-	USA 14. Race - Ame	ericen Indian
900	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates.		Yes, specify Cul	Hispanic Origin? (Spoan, Mexican, Puert	o Rican, etc.)	Black, Whit	te, etc.
215-(	n 72 hou a <b>n "nat</b> Medica	Completed	15. Decedent's Edu (Specify only highest grade	completed)	I (Give I	lent's Usual Occu kind of work done O NOT use retired	during most of wor	king	16b. Kind of Business	
1212	iled within I Hygiene. other tha /ent, the N	100	Elementary/Seconday (0-12) 1 2	College (1-4 or 5+)	Data	Proces	sor/Man		Citi Ban	K
/lanc	should be file n and Mental H 7 is marked o raumatic eve	일	17. Father's Name (First, Middle, Last) Luther Adolph Sm Willard Hines	ith Sr Smith					Maiden Surname)  Y Mildred l	Hines
Baltimore, Maryland 21215-0036	id 2 shoul		19a. Informant's Name/Relationship (Types Denise Isaac-dau						er, City or Town, State, Z ney, Maryl	
more			20a. Method of Disposition 1 ☐ Burial 2★☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ev	Place of Disposementery cremetery cremetery	sition (Name of natory of other pl ral Ch n Ser. Bel	äpel 6	Date -13 - 11	20c. Location - City o	
Balti	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee						and Crema	tion Service 21234
		Н	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the dec						Approximate
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	can	cer				Interval Between Onset and Death
	Examiner			Pue to (or as a conse						1/1950/5
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Bloud	quence of):	°US (05)				1950's
	executed ian and irial-transi	l= 1	that initiated events c. resulting in death) Last	Due to (or as a conse		03107			<u>-</u>	77503
200	icate be j physic s the bu	ledica	d							
. Box 68760	The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregr 1  Live Birth 2  Fe 4  Pregnant at time o 9  Unknown	etal death 3 🗌	Ectopic pregna Other (specify)	ncy		23d. Date of de Month	blivery Day Year
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Jo u	<b>ding Physi</b> cia <b>n:</b> h. After this certific funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju	ıry at rk?		now injury occurred	
Division of Vital Records,	ospital or Attending hours after death. uneral Director: After ed filled in by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec			Yes 2 No	28f. Location (S City or Tow	Street and Number or Ri vn, State)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer	edical	(Check  Medical Examine		ion and/or invest	igation, in my opir	nion, death occurred	at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the H within 24 To the Fu complete	Σ	only one) 3 L Certifying Nurse  29b. Signature and title of certifier	Practioner: To the best of	my knowledge, c		se number	ace, and due to th	29d. Date signed (Mon	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Month 5:30 A M Julius Elliot Eitington June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 3618 Littledale Road Kensington 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1<u>918</u> Days Min Illinois Director Mar 93 347-07-4598 Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No 28a-f MD Montgomery Kensington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a ( Funeral USA 20895 3618 Littledale Road or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after 2 No Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates. event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Writer/Manager Government and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rose Gordon Erwin Eitington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3620 Littledale Road Kensington, MD 20895 Norma Eitington/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Final Journey Crematory 06/08/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ a Corebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner b Dysphasia Sequentially list conditions unity for as a consequence of if any, leading to immediate cause. Enter Underlying Examir Hypertension The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ysician and e burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 phys the t ading p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? ρ Month Year Pregnant at time of death Day Yes 2 No ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2X No Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) director Hospital Other: 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Lacktifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) June 3, 2011 D53691 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

Registrar

State

Tower Oaks Blvd. #110 Rockville, MD 20852

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Oil Physician/ 2:27 PM Jack L. Etter, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town. or Location of Death 4c. County of Death Examiner Baltimore Simou Hospital Batimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🛛 M 2 🗆 F Hours Min. Days 56 Maryland 214-64-3304 **Director** Usual Residence of Decedent 10b. County 28a-f shov 10a. State 10c. City Town or Location 10d Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛛 No Jarrettsville Harford Maryland 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a United States 21084 2752 Azure Court 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc.
White ō þ 1 Never Married 2 Married Yes 2 No 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) None Disabled 8 other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers of the second ပ be 1 Frances M. Joy Jack L. Etter, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2752 Azure Court Jarrettsville, Maryland 21084 Jack L. Etter, Sr. / Father 20a. Method of Disposition 20b. Place of Disposition (Name of June 11, 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Evans\*Funeral\*CHabel 2011 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Bel Air Signature // Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service-BelAir any 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or contribications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Dav Year ☐ Pregnant at time of death☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate | 2 N Yes To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ပ 1 npatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending work 1 🗌 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of certifie 29d. Date signed (Month, Day, Year) RES-000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (nau 31. Date filed (Month, Day, Year)-State

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Registrar

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Baltimore,

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ILAY.	Funeral Director		5. Social Security Number 238 - 0 4 - 0 Usual Residence of December 238 - 0 4 - 0	0366	х Дм 2 <b>Г</b> 7.7	Ag (In yrs la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y Year 54	9. Birthp	lace (State or Foreign (Carolina
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Baltimore,	t. Page tment tant: I		1 ☐ Burial 2 🔀 4 ☐ Donation 5	Other (Specify	0		-site	Cremat	cory 06				
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<b>D</b>	/	-	fame and address	of) erson who co	onis eted cause o	death (Item	23a) (Type, P	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	142-	. 64 ~	10	2/11	. N. ()

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Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 5:29 PM Tina Annette Edwards Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign County) 8. Date of Birth Funeral Social Security Number 7. Age (In vrs. last birthday) Days Hours 0790377964 1 □ M 2 🕱 F 66 Ink **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoiury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2449 Shirley 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married Completed by 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: Black 3 
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 10th Grade College (1-4 or 5+) N/Ahomemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Evelyn Edwards Mack Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 N. Bentalou St., Baltimore, MD 21216 Evelyn Edwards (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott Mt. Zion Cemetery 06/10/11 Baltimore, MD 21. Signature of Funeral Service Licensee Forephades of Brown Jr. Funeral Home PA 2140 n. Fulton Ave., Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann f Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Tying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number D 005353 9

DHMH 17 Rev 7/2009

State Registrar 29b. Signature ar

20be

Memorial Hospito

cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8440 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ June 8 <sup>Day</sup> 2011 Debra Lynn Ferrell 2:52 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4949 Tuscarora Road Tuscarora Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min. Mar 28 <sup>Year</sup> 1963 Director Virginia 288-64-9054 48 Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Tuscarora 1 ☐ Yes 2 🔀 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4949 Tuscarora Road 21790 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married 72 hours after Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event. The Medical Process. 1 ☐ Yes 2 No Specify: Completed 3 - Widowed 4 - Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard Watson Drummond Martha Mae Farr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4949~Tuscarora~Rd.~Tuscarora_{\it I}~MD~21790$ Michael L. Ferrell/husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Journey Crematary 06/11/11 Woodbine, MD Signatural Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD MD 21029 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate List only one cause on each line Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) ear Medical Due to (or as a consequence of): Examiner 0 eaves Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause initializes or iinjury Dus to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed ttending physician and or use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day the cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate! performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **X** No 1 Tyes ြု 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Sesidence 6 Other (Specify) 27. Manner of De 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier d ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 0

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUME 6 2011 Josephine Anna Fox 2:45a М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Senior Living Baltimore County Baltimore Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days July 16 1924 Baltimore, Maryland 217 24 6645 Yrs. **Director** 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Virginia Fairfax Burke 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6102 Covered Bridge Road 22015 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2XX No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4X Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Principal Baltimore Co. Bd. of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry George Krotee Sr Ruth Lillian Hermann 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 6102 Covered Bridge Road Burke, Virginia 22015 Arthur L. Fox (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. June 7 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) signature of Funeral Service censee 22.Name and Address of Farility 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death use on each line. shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 9 Unknown IJnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Forillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ️ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Certificate: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination allows investigation, in this opinion, according to the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) Run AD DOWN BY temmers 617 31. Date filed (Month, Day, Year) State 1 0 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 12:05 AM JUNE 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 0 If Under 24 Hrs. 6. Sex A. Birthplace (State or Foreign 7. Age (In yrs. låst birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 2 M 2 □ F Months Days Hours Min. Director 7-26--10-Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar paust be notified at 1 es 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or U.5.A Funeral 2/2/ FURST or items 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 9 Specify 3 Widowed 4 Divorced CHISEESE "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) It item 27 is marked other the protection of the 17. Father's Name (First, Middle, Last) 18. Mother's Name, (Ffrst, Middle, Maiden Surn Be ٩ 19a. Informant's Name/R = tionship (Type. Print) Ms 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/262 LTO, 10 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o once. Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facili 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima Interval B ween Onset and Death Immediate Cause (Final anythemicy **Physician** Cardiac 15 min460 disease or condition resulting in death) /Medical Due to (or as a consequence of): Atheroscieratic health disease 5443 **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hypenionsion 545 or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Conjustive heart failure 11 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye ar 5 ☐ Other (specify) been signed by the should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Brain tumor 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐Yes 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 11 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d, Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D304014 + DUSHIMD 6-3-4011

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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32. Redistrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June MELDDY FLOWERS 9:00 D. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore n/a 1403 Ostend Street If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛚 F Months Days Hours Min. 11-08-1850 MD Director 214-62-5940 54 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21223 USA 1403 Ostend Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Completed by Black, White, etc. 1 X Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. should be filed within 72 hours aft. and Mental Hygiene. If Yes, Give Specify African-American 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Atlas Flowers Jr. Gertrude Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health Marcus J. Stewart/Son 1403 Ostend Street, Baltimore, MD 21223 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State Metro Crematory Baltimore, MD 6-10-2011 4 Donation 5 Donation Other (Specify) of Funeral Service Cicenses 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BROINC HITI CHRONIC EMPHYSEMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ☐ Pregnant at time of death☐ Unknown cate has been signed by the a page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 00 욘 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? Division 2 🗌 No Accider
Suicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 14607 2011 MO BM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO BACTIMORE EDMONDSON GE UNIVERSITY CARE ESE 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James E. George 2:20P M Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Cente Towson Baltimore . Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 XM 2 🗆 F Days Hours Months Director 6/4/1945 212-44-8319 66 Usual Residence of Decedent show 10a. State 10b. County be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 28a-f s 1 Yes 2 No MD Carroll Westminster ò 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a ( 1108 Martinez Dr. USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify. If Yes, Give Year or Dates, 1981-83 3 Widowed 4 Divorced Specify: White marked other than "natur imatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene.  $\tilde{12}$ Auto Mechanic State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert George Mary Caldwell Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Sherian J. George/Wife 1108 Martinez Dr., Westminster, MD 21157 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 6/10/2011 Finksburg, MD permit. 21. Signature of Funeral Service Licens 22Burrier Outern'y Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Fart 1. E fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, heart failure. List only one cause on each line. Interval Between Onset and Death RRHYTHMIAS, CARDIAC ARREST Ph sician/ dise se o condition resulting in death) Medical Due to (or as a consequence of) Examiner SCHEMIC CARDIOMYOPATHY Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant
Unknown Month 1 ☐ Yes 2 12 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAL ARTERIAL DISEASE cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLEUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy OSTED MY ELITIS performed certificate OF 1 Yes 2 No 1 ☐ Yes 2 € Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completed filled in by the fu Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number MO 00060687  $O_{\times}$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MO GIREATER BAITIMORE MEDICAL CTR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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	Examin	er	4a. Facility Name <i>(if r</i> Baltimo				ca1	Ctr	4b. City, Towr	or Locat				County of De		
	Funeral		5. Social Security Nu	mber	6. Sex 1  M 2	7. Ag	e (In yrs. la	ast birthday)	If Under 1 Ye	ar If U	nder 24 Hrs.	8. Date of Bi	irth	9, 8	Birthplace (State of	
	Director ≥		216-48- Usual Residence of C	Decedent		•	64	Yrs.				Jan 16	7, 19	4/   W	est Virg	inia_
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9036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. article file more is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.e.	þ	11. Marital Status 1 ☐ Never Marrie 3 ፟፟ Widowed 4		ied 1 If Yes	Decedent E ed Forces? Yes 2 X s, Give or Dates.			Vas Decedent of Yes, specify C			ecify Yes or No Rican, etc.)		Black, WI	merican Indian, hite, etc. white	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i		20a. Method of Dispo 1  Burial 2 <b>X</b> 4  Donation	Cremation		from State		emetery, crem	sition (Name of patory or other p Cremato	olace) <b>ry</b>	6/10/	Date <b>2011</b>	1	cation - City n Burn	or Town, State	
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~ P	h sician/ Medical		Immediate Cause (F disease or condition resulting in death)	inal	a.	Sit each line		A1-2	hin	v's	Da	nent.	C		Interval Bety Onset and D	
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Division of Vital Records,	To the floogstal or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page?	l Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could r determi	28e. F	Place of Injur ouilding, etc.	ry - At ho . (Specify)	me, farm, stre )	et, factory, offic	е		28f. Location ( City or To		Number or F	Rural Route Numbe	er,
1	the mosturing the control of the funer of th	Medical	(Check 2 <sup>4</sup>	Medical Ex	caminer: On the	e basis of ex	camination	ı and/or investi	ccured at the til gation, in my op eath occurred at	inion, dea	th occurred at	the time, date a	and place,	and due to th	e cause(s) and mar	iner stated.
	with Con		29b. Signature and tit	tle of certifier	bun	m			29c. Lice	$^{5}$	703	6	29d. Date	signed (Mor	anth, Day, Year)	
			30. Name and addres	s of person w	no completed	cause of de	ath (Item	23a) (Type, R	int) Don	Y-1	In	- Che	te	Mo	21619	,
	State Registra	9	31. Date filed (Month,	Day, Year)	2011	32. Pegistra	r's Signati	ure	. 4.1				-			

11-03770 Roy Maxwell G	rant							<b>copies Are L</b> otal Hygiene	egible	).	
		1- For State Registrar		Cert	ificate of	Death			Reg. No.	20	1 8446
Physic Medical Exam		Decedent's Name (First, Middle,Last)     Roy Maxwell Gr		_				2. Date of De Month May 19,	Day	Year	3. Time of Death 0452 hrs
		4a. Facility Name (if not institution, give Prince George's Hospital C		ber)	4	b. City, Town, o	r Location o	f Death		County of	
Funera		5. Social Security Number unk6. Sex	7.	Age (In yrs. las	st birthday)	If Under 1 Ye		r 24Hrs. 8. Date of E	Birth (MM/	DD/YYYY)	9. Birthplace (State or Foreign unk
Director		Usual Residence of Decedent	M 2 F	46	Yrs.		ys Hours	Nov	16,		Country)
daryland 28a-f show any 1 at once,	Į.	10a. State unk 10b. County	un	ık 10c. City, T	own or Location	on				unk	10d Inside City Limits unk 1 Yes 2 No
r death with the Maryland or items 23a or 28a-f abo must be notified at once.	I Director	10e. Street and Number			unk	10f. Zip Code		unk	10g. Citiz	zen of Wha	t Country? USA
after death wir al", or items ?	by Funeral		12. Was Deced Armed Forc 1 Yes If Yes, Give Year or Dates:	es? 2 Noun	k If Ye	es, specify Cuba	n, Mexican, specify:	in? ( Specify Yes or N Puerto Rican, etc.)		14. Race - White,	American Indian, Black, etc. black
036 Ithin 72 hours ne. r than "natur'	Completed t	15. Decedent's Education (Specify only Elementary/Secondary (0-12) unk	y highest grade College (1-4 Ink		16a. Decedent during mo	's Usual Occupa est of working life	ation (Give k	ind of work done unuse retired)	k <sup>16b. K</sup>	ind of Busin	ness/Industry unk
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene in 77 is marked other than numatic event, the Medical	Be	17. Father's Name (First, Middle, Last)		1		unk		s Name (First, Middle			unk
	To	19a. Informant's Name/Relationship (Tyle O • C • M • E • 20a. Method of Disposition  1 Burial 2 Cremation 3			900 W	. Balti	more S	Street Bal	timo	re, M	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 X Other Specify: 21. Signature of Fungaral Septices icons	in/st/a	rector	<sup>22</sup> SN <sup>a</sup> Ba	ate Addres 1timore	toffacility Tomy	3oard 655	W. B	altim	ore Street
Physician /Medical Examiner		23a. Fart I. Enter the disease, or complication. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	h line. Occlusiy	ve Pulm	onary 1	e mode of dying	, such as ca	rdiac or respiratory a	rest, sho	ck, or heart	Approximate Interval Between Onset and Death
			ue to (or as a co Leg Deep			sis					
	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a co								
executed an and al - transit		d. XX UNPENDED	AMENDED 23	3a-b,27	per me	.g916 6	-13-1	1 sm			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, out	come of pregna	ncy 2 Feta		Ectopic			. Date of de	blivery Day Year
O. Boy at the death I by the att	hysi	1 Yes 2 No 9 Unknown	9 Unknown			_		Loo Bu			
IS, P.O. quires that th en signed by	Š	Part II. Other significant conditions	contributing to de	eath but not resi	ulting in the un	iderlying cause	given in Par	1 Ye	s 2	No 3	te to the cause of death?  Probably 4  Unknown
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ion of tending Phase to: The After to the funeral	ation: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of I (Month, Da	njury 2 y,Year)	8b. Time of Inj	· I _ :	ry at Work? Yes 2 I		how inju	y occurred	
Division And ours at er of cours at er of course ours filled in by	Certification:	3 Suicide 6 Could not be determined	28e Place of	f Injury - At hom	e, farm, street,	, factory, office b	ouilding, etc.	28f. Location or Town,		d Number	or Rural Route Number, City
Divis To the Hospital or At within 24 hours all or d To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: Cartifying Physician Certifying Physici		xamination and							
	Ž	29b. Signature and title of certifier	V			29c, Licens O.C.				ate signed 20, 2011	(Month, Day, Year)
		30. Name and address of person who con Ling Li, MD Assistant Med	•			Street, Balt	timore, M	D 21223			<del></del>
S	ate	31. Date filed (Month, Day Year)	32. R	rac's Signature							· · · · · · · · · · · · · · · · · · ·

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2011 David Α. Hartley 7:40a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2424 Harkins Rd. White Hall Harford Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 <del>∏</del> M 2 □ F Months 04-24-1947 North Carolina Director 212-44-1859 64 Usual Residence of Decedent ms 23a or 28a-f show must be notified at e filed within 72 hours after death with the Maryland tal Hygiene. and other than "natural", or items 23a or 28a-f sho ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notitied at 10a, State 10h County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Harford White Hall 1 🗌 Yes 2 🙀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2424 Harkins Rd. 21161 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give 1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates.1966 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 yrs Carpenter Construction Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveniany 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alvin Hartley Loretta Chanult 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Hartley wife 2424 Harkins Rd White Hall, Md. 21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6-07-2011 Glen Burnie, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Schimunek F 610W. MacPha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ ACUTE MYOCAR DIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or) Exami attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ OBSTRUCTIVE LUNG Completed 1 SYes 2 □ No 3 □ Probably 4 □ Unknown TYPE C HEPATITIS CIRNHOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No ☐ Yes 2 🗖 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မ in 24 hours after ucau. **he Funeral Director:** After this or anleted filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Sulcide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Andrew Nowaleous DO8096 JUNE 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

35

INDROW NOWAKOWSKI MD

31. Date filed (Month, Day, Year)
JUN 1 0 2011

FULFORD

ATE. BEDAIR, MD 21014

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Provided to the common of the	Balt	permit. Departr Import. any inji			2. Name and Address of Facility.  ILLIAM C. BROWN COMMUNITY FUNERAL HOME P. A.
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  R 26 821 N with st Bactim one nel 2120  State 31. Date filed (Month, Day, Year) 32. Recipitrar's Signature	Ä	Noth Com		29b. Signature and title of certifier	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  R 206  821  With ST  Bactim are not 2120  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		No. le		Mien-6 1, out in	0.31865 6/6/11
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Registrar JUN 10 2011 According		Registra	_	JUN 1 0 2011 Denue . 19	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2011 /Medical 4. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner S 10 w n 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🕶 F Months Days Hours Director -29-1920 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Director 7000 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 ☐ Divorced ac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ess/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Cott ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Witherspan 620 Hopeton Jose して 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 Donation North Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Inter the shock, or heart Immediate Cause (Final **Physician** ATHEROSCLEROTIC disease or condition resulting in death) CARDIOVASCULAR TISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or se's consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No 5 Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Periphera Vascular 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy perform After this certificate or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) 1 Yes 2 No death within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hybician 2011 old Court 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVVERAHALLI HARISH 21133 Randalistown MD 31. Date filed (Month, Day, Year) State **JUN 10** Registrar

			For State Registrar	State of Marylan		artment of i tificate of i		Mental Hy	/gien Reg. N		
	Physici	an/	1. Decedent's Name (First, Middle, Lass Leslie R. He					2. Date of De	eath	ay Year	3. Time of Death
) 	Medi Exami		4a. Facility Name (if not institution, give			4h City Town o	or Location of Dear	June	9		4:30a M
			Stella Maris	Hospice		Towso			4	Baltir	
	Funeral Director			7. Age (In yrs. le		If Under 1 Year Months Days			rth av, Ye <i>ar)</i> 2	9. B	Sirthplace (State or Foreign Country)  Iowa
	faryland 8a-f show tified at	ector	Usual Residence of Decedent		y, Town or Loc	cation lle Rive	er				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the N is 23a or 2 nust be no	Funeral Director	10e. Street and Number 100 Village	Green Lane		10f. Zip Code 2122	20			Citizen of What C	
9800	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. I health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married - 3 ☐ Wildowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates.		Vas Decedent of H Yes, specify Cuba		pecify Yes or No- to Rican, etc.)		14. Race - Am Black, Wh Specify: W	ite, etc.
21215-0036	led within 72 hou Hyglene. other than "nat ent, the Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12) 12th		(Give k life. DC	ent's Usual Occup kind of work done of NOT use retired) Ck Driv	during most of wo	rking	ł	Kind of Busines	
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, Man	and 2 shoul Health and I tem 27 is ma		19a. Informant's Name/Relationship (Ty Cynthia Watkir		19b. Mailin	g Address (Street ) Villag	and Number or Ru Je Greei	ural Route Numbe	er, City o Bal	or Town, State, Z	Zip Code) D 21220
Baltimore,	~ O += -		20a. Method of Disposition  1   Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State C6	metery, crem	sition (Name of latory or other place of Memo	ries 6,	Date /15/11		ocation - City o	or Town, State
Ball	permit. Page Department Important: I any injury o		21. Sign wire / F neral Servi / License	& Ball		Name and Addres	v Funer	cal Hom	e c	ve. Ba	alto. MD
- 34	hysician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	lications that caused the death to cause on each line.  a. CEREBROVAS(  Due to (or as a consequence)	CULAR		g, such as cardiac	c or respiratory an	rest,		Approximate Interval Between Onset and Death
0	ificate be executed g physician and as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque							
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	a. If yes, outcome of pregnan  1	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of de	elivery Day Year
ds, P.O.	v requires that to been signed be should be deta	by	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the un	derlying cause giv	ren in Part I.	23e. Did to		_/ _	o the cause of death?
Recor	Physician: The law requi this certificate has been al director, page 2 should	Completed						24a. Was a autop perfo		prior to	utopsy findings available completion of cause of
Division of Vital Records,	nding Physicial ath. r: Affer this certil e funeral directo	Certificate: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Notural 5 Pending 2 Accident Investigation	ospital:  1	ER/Outpatient 28b. Time of injury	3 DOA Othe	4 □ Nursing H at	ok only one)  lome 5  Resid			city) HOSPICE
Division	ital or Atte irs after de al Directo ied in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree			28f. Location (S City or Tow			ıral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	only one 3 X Certifying Nurse	cian: To the best of my knowled er: On the basis of examination a Practioner: To the bast of my k	and/or investig	gation, in my opinio	n, death occurred a fine, data and pla	at the time detect	nd place	and due to the	saying (a) and manner stated
0	Q 2√V		29b. Signature and title of certifier	ESCANP		29c. License	number 14474	2	29d. Da	te signed (Mdnt.	h, Day, Year)
	0 84		30. Name and address of person who co  JACKIE JONES, CR	NP 2300: DULAN	EY VAL	•	TIMONIU	M. MD 21	L093	<i>t t</i>	
	Stat Registra	_	JUN 1 0 2011	32. Registrar's Signatur	Kel						

JUNE 9, 2011 4:30 a.m.

LESLIE HEIDEMANN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, item# 15, per fh, g916, 6-10-11, sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:30 PM 2011 June 7, Howard Washington Houseman Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Nursing & Rehab. Center-Riv rside Bel Camp Harford 7. Age (In yrs. lass 5. Social Security Number last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**≥**M 2 □ F Months Days Hours Jun 13, Year 1931 Director 207-22-2384 Pennsylvania Usual Residence of Decedent fshow 10a. State other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 28a-f MD Harford Aberdeen 1 & Yes 2 \ No ö 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a 621 Walker St. 21001 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ō 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ➡No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other tranmary injury or other tranmariany injury or other tranmaria. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman 10 Best Battery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Washington Houseman Wagner Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon Houseman /Son 27 Christian Ln. Rising Sun, MD 21911 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 Fremation 3 ☐ Removal from State cemetery, crematory or other place Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Mory 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital. Other: 2XNo မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) funeral 27. Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident М Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Day, Year) At death (Item 23a) (Type, Pric 30. Name and address of person who completed caus THOUS 31. Date filed (Month, Day, Year) State Registrar

Box 68760

P.O.

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18453 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:38AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death ltm If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year)
Nov 22, 1920 5. Social Security Number 7. Age (In vrs. last birthday) Yrs. 9. Birthplace (State or Foreign **Funeral** M 2 □ F Months 503-14-1830 **Director** South Dakota Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD <u>Baltimore</u> 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1101 N. Calvert Street #502 21202 USA items filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinone. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔽 No Specify. Completed 3 X Widowed 4 ☐ Divorced 43-46 Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 <u>special agent</u> IRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Melvin Bernard Iverson Amelia Elizabeth Wiseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Sauter/daughter 7084 Saddle Drive Eldersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 D Other (Specify) 21. Signal re Funeral Service State Anatomy Board 655 W. Baltimore Street Wad Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. autopsy perforn 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5  $\square$  Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. unly und Gertifying Nurse Practioner: To the best of my knowledge, de consented at the time, date and clane 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Vincent Imrisek 20ÎÎ 5:55 A. M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 07/1<u>7/1924</u> 1 X M 2 □ F Months 204 12 7955 86 **Director** PA. Usual Residence of Decedent 28a-f show with the Maryland 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral U.S. 21061 22 Rosedale Avenue "natural", or items edical Examiner mu Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced WW II Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) than Elementary/Seconday (0-12) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Salesman Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Imrisek Catherine Buda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Glen Burnie, Maryland 21061 Joan Imrisek / Wife 22 Rosedale Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State 06/09/2011 Elkridge, Maryland Meadowridge Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Fyneral Service La 22. Name and Address of Facility Gonce Funeral Service, P.A.
4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph.sician/ disease or condition seved years Medical resulting in death) **Examiner** several years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hypertension, Myastrenia Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Hyperupide mia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🕻 No 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 X Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

June 6, 201) · aleton Lajorun 127541

Registrar
DHMH 17 Rev 7/2009

State

2\*1

31. Date filed (Month, Day, Year)

JUN 4 0 2011

Baltimon MD 21227

Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEETHA RAJA MD, 4367 Hollins Famy

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 4 Carl D. Jones June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs 8. Date of Birth 5. Social Security Number . Age (In vrs. last birthday, **Funeral** Min. Apr 4, 1929 Hours Months Days 1 📉 M 2 🗆 F 82 Director 220-20-2898 Usual Residence of Decedent Show 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21234 9124 Naygall Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. ò permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 N Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) televisions repairman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Krueger ပ္ Edward Jones 2011 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4312 Blakely Avenue Nottingham, MD Jeffrey Jones/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signature uneral Service Ronal ি শুলাইল প্রার্থিক প্রতিনিত্ত Board 655 W. Baltimore Street censee Wade 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deat CHRONIC OBSTRUCTIVE PULMONARY DISEASE Physician/ Medical Examiner Sequentially list conditions. d any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a por sequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month been signed by the should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv After this certificate has funeral director, page 2 s performed? Yes 2 X N 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending death. Investigation 24 hours after deat e Funeral Director. 6 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner 1.1 is boat of my included, Seth occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

3 X Certifying Nurse Practioner: To the best of my knowledge, death coour

ss of person who completed cause of death (Item 23a) (Type, Print)

3:10 AM M

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

death?

29d. Date signed (Month, Day, Year)

Year

HOSPICE

1 ☐ Yes 2 🛣 No

Maryland

white

State Registrar DHMH 17 Rev 7/2009 (Check

29b. Signature and title

30. Name and add

31. Date filed (Month, Day, Year)

JACKIE JONES, CRNP

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			Certifi	icate of	Death			R	eg. No.			
Physicia Medical Exami	an/	Decedent's Name (First, Midd LAUREN KOWATCH							2	2. Date of Dea Month June 7, 20	th Day	Yea		3. Time of Death 1524 hrs
		4a. Facility Name (if not institution Upper Chesapeake M		mber)		4	b. City, Town, o Bel Air	or Location	of Death			c. County of Harford	f Death	
Funeral Director		5. Social Security Number 213-72-9639	6. Sex 1 M 2 F	7. Age (II 40	n yrs. last b	oirthday) Yrs.	If Under 1 Ye Months Da	ear If Under		8. Date of Bir 11/10	th(MM/ /197	70	Foreign	hplace (State or n MD untry)
Maryland 28a-f show any d at ooce.	'n	Usual Residence of Decedent  10a. State 10b. County MD HARF			c. City, Tov BEL A	vn or Locatio	on							10d. Inside City Limits 1 Yes 2 No
th the Maryli 23a or 28a-f	Il Director	10e. Street and Number 1222 JENNY RD					10f. Zip Code 2 1014				USA	izen of Wh	at Coun	try?
after death wi	by Funeral	11. Marital Status 1 Never Married 2 X X 3 Widowed 4 Div	larried 12. Was Decinarried Armed For 1 Yes vorced If Yes, Give Year or Dates:	orces?		If Ye	Decedent of H s, specify Cuba Yes 2 X		, Puerto R			14. Race White Specify:	etc.	en Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injary or other traumatic event, the Medical Examleer must be notified at noce.	Completed to	15. Decedent's Education (Spe Elementary/Secondary (0-12)	ecify only highest grad		ted) 16a		s Usual Occup st of working lit AKER				İ	Kind of Bus √N HOI		ndustry
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	8	17. Father's Name (First, Middle, GERARD COMEN						SHEI	LA J	First, Middle, M ENKINS				
and 2 should seath and M tem 27 is m traumatic c	2	19a. Informant's Name/Relations MICHAEL KOWATC 20a. Method of Disposition			1	l222 J	Address (Street ENNY RI	) BEI	AIR	mai Route Num  MD 2  Date	1014	+		Zip Code)
Baltimore, permit. Pages I a Department of Hes Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other St 21. Signature of Service	pecify:		crem HIGHV			ss of Facility		3/11	FA	ALLST	ON,	
Physician	-	23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	aused the	death. Do	610	W. MAC	CPHAIL	. RD	BEL A	IR,	MD 2	1014	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death)		conseque	ence of):									Between Onset and Death
0	mlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Due to (or as a											
7760, ficate be executed g physician and the burial - transit	VMedical Examiner	events resulting in death) Last  UNPENDED	Due to (or as a	conseque	ance of):									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ian/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	rth		2 Feta	I death 3	Ectopic	pregnanc	гу		i. Date of o	lelivery Da	ay Year
P.O. Box 68 res that the death certifus signed by the attending be detached for use as	Physician	1 Yes 2 No 9 V Unk	known 9 Unkno	wn	e of death		er (Specify) derlying cause	given in Pa	irt I.	23e. Did to	bacco u	use contrib	ute to th	ne cause of death?
rds, P.( requires that been signed hould be deta	leted by	**							_	24a. Was a	an	24b. W	ere auto	opsy findings available
tal Records, cian: The law requirectificate has been sector, page 2 should	e Completed	25. Was case referred to medical					26.Plac	e of Death	(Check onl	autops perfor 1 Yes 2	med?	de	ath?	mpletion of cause of
n of Vita	on: To Be	examiner? 1  Yes 2 No 27. Manner of Death 1 Natural 5 Dead	28a, Date of	of Injury	28b	Outpatient  Time of Inju	ury 28c. Inju	ury at Work	? 28	Home 5 1 1 Bd. Describe h ubject hang	ow inju	iry occurre		
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Fuocral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	Certification:	2 Accident Inves 3 Suicide 6 Could deter	stigation Jun 7, 20 28e. Place	of Injury	143	39 hrs farm, street,	factory, office	Yes 2	c. 28	Bf. Location (S or Town, St 222 Jenny Ro				al Route Number, City
To the Hospi within 24 hou To the Fuser completely fil	Medical Co	29a. Certifier 1 Certifying Pt	hysician: To the best miner:On the basis of and manner sta	of my kno f examina	owledge, d	eath occurre			ce, and du	ue to the cause	e(s) and	d manner a	s stated	
	352	29b. Signature and title of certified the signature of th	4. King	J4	, re	, D.		se number .M.E.	OCME			Date signed		h, Day, Year)
5		30. Name and address of person Theodore M. King, Jr.,	, MD. Assistar	nt Medi	cal Exan		00 W. Baltir	more Stre	eet, Balt	timore, MD	2122	23		
Sta Registi		31. Date filed (Month, Day, Year)  JUN 1 0 2011	Server 32. Reg	gistrar's S	Saul	4								
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**ORIGINAL** 

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or Pr					_		Legible.	
		For State Registrar	State of N	/larylan		artment of F tificate of L			Reg. No.	011	18457
Physicia	in/	Decedent's Name (First, Middle,     Masao Kuriyama	*					2. Date of De Month	Dav	Year Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution,				4h City Town o	r Location of Death	June		County of Death	2:40p M
Examin	ei	Wilson Health C				Westmin				rroll	
Funeral Director				ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Oct 29		9. Birth Cou Jap	nplace (State or Foreign ntry) an
d tow		Usual Residence of Decedent  10a. State 10b. County		I 10c Cit	y, Town or Lo	cation					10d. Inside City Limits
arylar a-fsh	ecto	,									1 🗆 Yes 2 🛛 No
the M	ΙĎ	MD Montgo 10e. Street and Number	-	TMOH	Lgomer	y Village 10f. Zip Code	<u> </u>			en of What Cou	intry?
h with	<b>Funeral Director</b>	20337 Bickleton	Place			20886			USA		
r deatl		11. Marital Status 1 ☐ Never Married 2 🔀 Marrie	12. Was Decedent Armed Forces  1  Yes 2	Ever in U.S	S. 13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	4. Race - Ameri Black, White	
safter ral", o Exam	q pe	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	INO		☐ Yes 2 🛚 No	Specify:		S	pecify:	anese
2 hour "natu	Completed by	15. Decedent (Specify only highes				lent's Usual Occup		kina	16b. Kin	d of Business Ir	
thin 73	Som	Elementary/Seconday (0-12)	College (1-4 or <b>5+</b>	5+)	Physic	O NOT use retired)		9	Feder	ral Gov	ernment
led wi Hygie other ent, tl	Be (	17. Father's Name (First, Middle, La			TITYDI	JISC	18. Mother's Nan	ne (First, Middle,			
d be fi dental irked itic ev	오	Zennosuke Kuriy	ama				Miyo Su	zuki			
d 2 should alth and halth and halth and halth are market trauma		19a. Informant's Name/Relationshi Tomi Kuriyama/w			19b. Mailir 2033	ng Address (Street : 7 Bicklet	and Number or Rui	ral Route Numbe Montgoi	er, City or To <b>ner</b> y	own, State, Zip Village	Code) , MD 20886
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	:	20a. Method of Disposition  1  Burial 2 X Cremation 3 4 Donation 5 Other (Sp.			cemetery, crer	sition (Name of natory or other place rney Crem	atory 06	Date /10/11		ation - City or T	
permit. P Departme Importar any injur		21. Signatore of Funeral Service Lic			Ğ	Name and Addre	ss of Facility Cremati	on Serv	ice 1	P.O. Bo	x 784
		23a. Part 1. Enter the disease, or o	complications that cause	MO1						rksvill 	e, MD 21029 Approximate
Physician/		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each lin	ne. In CH	4	pancre					Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as	s a consequ		puroc	WIC	COTE	<u></u>		
LXdiffille	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	e a consecu	nence off.						
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta at time of o	aldeath 3	Ectopic pregnand Other (specify)	СУ			3d. Date of deli Month	Day Year
hat the ed by detacl	y Ph	Part II. Other significant condition	s contributing to death	but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?
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aw rec as bee 2 sho	Completed							24a. Was			opsy findings available ompletion of cause of
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rsician: The law s certificate has b director, page 2 s	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		ED (0	_ Oth	ace of Death (Chec			7	
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al or Att s after d l Direct d in by 1	Certificate:	4 Homicide determin	28e. Place of In	ijury - At ho tc. <i>(Specify</i>		eet, factory, office		28f. Location ( City or To		Number or Rura	al Route Number,
Hospita 24 hours Funera ted fille	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of	examination	n and/or invest	tigation, in my opinio	on, death occurred a	at the time, date	and place, a	and due to the c	ause(s) and manner stated
o the vithin 2 omple	ž	only one) 3 Certifying I 29b. Signature and title of certifier	Nurse Practioner: To th	e best of my	y knowledge, o	death occurred at the 29c. License		ice, and due to th		and manner as s signed (Month,	
F > F 0		· aluk	L CE	RHAEC	L nurse	practure	R1396	631	61	18/20	0//
<b>√</b>		30. Name and address of person w Elizabeth A. Kin	ho completed cause of	death (Item	1 23a) (Type, F	Print)				-,	
Stat		31. Date filed (Month, Day, Year)		rar's Signa	ture		J/				
Registra	ar -	JUN T O ZOLL	( Basera P B	. 100	Calland						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201<sup>Yea</sup> JUNE 8:23P CYNTHIA E. KUHNERT Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 555 S. Marlyn Avenue "G" Essex Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year Months Hours Min. Marvland **Director** 218-68-7921 54 Dec 1956 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Ex∓miner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes XX No Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 555 S. Marlyn Avenue "G" 21221 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes XX No
If Yes, Give Black, White, etc. þ 1 Never Married 2XX Married Maryland 21215-0036 SpeWhite 1 ☐ Yes 2XX No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene, 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) 8th Grade Medical Records Clerk Medical Industry N/A injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Collurafici Elizabeth Rose Freidel and 2 should be Health and Metem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James L. Kuhnert (Husband) 555 S. Marlyn Ave. "G" Baltimore, Md. 21221 permit. Page 1 and 2 Department of Healtl Important: If item 2; any injury or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore. Marvland awn Cemetery <u>: 6-13-2011</u> <sup>22</sup> Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Balt 21. Signature of Funeral Service Licensee assen Baltimore. Md. 23a. Part 1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: that initiated events Due to (or as a consequence of): resulting in death) Last bunial-1 Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown Q Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes Hospital or Attending Natural injury 5 Pending 24 hours after death Funeral Director: A 2 No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifiei Certifying Physicians of the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinat: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certiffing Ninse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. f. On)the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Within 2 To the P 29b. Signature and title of certifier 10011 HOOS7173 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 9110 Philadelphia Rd, Ste314, Baltimore, mo 21237 Bahrain Huzefa 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04-20 Edward Ray Kelley 7:250M 06-Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nicomico bur 105pice 8. Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ★ M 2 □ F Months Jan 27, 1948 Director 218-48-5623 Virginia 63 Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Crisfield Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 90 Somers Cove Apts 21817 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Completed Specify: 3 X Widowed 4 Divorced 15. Decedent's Education unk 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Berkley B. Kelley Lois Lesceallette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2239 Groton Road Pocomoke City, MD 21851 Janice Elliott/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state 21. Signalure Superal Service Li ensee Director State and Ades of yackboard 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Die to (or as a consequence of): Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this n 24 hours after death.

In Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 \(\sime\) Yes 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical \*\*Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 06-05-2011

State Registrar 5302 CHINABERRY DR., SALISBURY, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLUSO

11-04096 Kathi Lee Kelley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) June 1, 2011 0605 hrs **Medical Examiner** Kathi Lee Kelley 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harford 1216 Janet Drive Edgewood If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director CountryMaryland 1951 217-54-4039 1 M 2 X F 60 9. Feb. Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f shov Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Harford Edgewood rector 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21040 USA 1216 Janet Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No Specify: White If Yes, Give Year 1 Yes 2 No specify: 4 Divorced <u>a</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 12 Electronics Assembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edsel Lee Kelley Rebecca Janice Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4841 Vicky Road, Nottingham, Christa Hopkins / Sister MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 K Removal from State 6-10-11 ahmansville Cemetery Lahmansville, WV 4 Donation 5 Other Specify 22. Name and Address of Facility Home, P.A. Road, Abingdon McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 21009 Approximate Interval **Physician** Between Onset and failure. Listonly one cause on each line /Modical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): ceuse: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed sician/Medical UNPENDED AMENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Ę, 1 Yes 2 ✓ No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? . death? Yes 2 No page 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 After this 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural 1 Yes 2 No Director: 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 6 Could not be 3 Suicide or Town, State) determined 4 \_\_ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 2, 2011 O.C.M.E San 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

**ORIGINAL** 

11-04173 Carlton Thomas Le		<b>ase Type o</b> State o	r <b>Print in l</b> of Marylan	d / Depa	rtment of	Health a				egible.	Comme	1846
Physician/	Registrar	(First, Middle,Lest)	-	Cer	tificate of	Death ——		2	. Date of De	Reg. No.	UI	3. Time of Death
Medical Examine	Carlton	Thomas L			· · · · · · · · · · · · · · · · · · ·				Month June 3, 2	2011	rear	0920 hrs
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Funeral	5. Social Security Nu	ımber 6. Sex	7.	Age (In yrs, la	ast birthday)	If Under 1 Y			8. Date of B			thplace (State or
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an d	Usual Residence of I 10a. State 1	Decedent 0b. County		10c. City,	Town or Locatio	n						10d. Inside City Limits
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Thomas M 19a. Informant's Nam	laddrey ne/Relationship (Ty	pe, Print )		19b. Mailing	Address (Str	Eur eet and Nu	<u>cille</u> ımber or Ru	AMOS ral Route Nu	ımber, City or T	own, State	, Zip Code)
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D. Box 68760, the death certificate be exectly the attending physician at ched for use as the burial - Physician/Medica	1 Yes 2 No		9 Unknown						Too sur			
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Dispital oppital of filled Cert	4 Homicide	determined			/ Rowhouse					t Court , Baltir		
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	(Check only 1 Cone) 2 V	Certifylng Physicia Redical Examiner:	n the basis of e	xamination ar								
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5	D~		-			0.0	M.E.			June 4, 2	011	
	30. Name and address Donna M. Vir		mpleted cause o			V Baltimo	re Street	Baltimo	ore. MD 2	1223		-
State			0	tran Signati		Daimino		., Dailinic		,220		
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tourier contine		1- For State AME1 Registrar	ite of Maryland / D nd #19a Per Fi	Certificate of	Death Death	іаі пуд	Reg.	201	1 1846
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Funeral		5. Social Security Number		yrs. last birthday)	Randallstown  If Under 1 Year   If Under	er 24Hrs.   8	. Date of Birth	Baltimore (	County  Birthplace (State or
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ould be d Ments is mark	To Be	19a. Informant's Name/Relationshi	p (Type, Print) MOther	19b. Mailing	Address (Street and Numi	ber or Rura	TUM ()	h <i>ries</i> er, City or Town, S	tate, Zip Code)
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More, Pages I and lent of Healt int: If item		1 Burial 2 Cremation	3 Removal from State	Gernatory or other		1-12	8-25//	Ballin	A A CR MI
Baltimore, permit. Pages 1 as Department of He Important: It ite	Ì	4 Donation 5 Other Spe 2 Sign ture of Furteral Service L		(5) (een 22. Na	me and Address of Facility	Vaugh	C.a.	eene Fim	ent services
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/Medicar Examiner		Immediate Cause (Final disease	n each line. a. <mark>Intraoral Gunshot w</mark>						Between Onset and Death
		or condition resulting in death)  Sequentially list conditions,	Due to (or as a consequer b.	nce of);					
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8760 tificate I	Me Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		death 3 Ectopic	pregnancy		23d. Date of deli-	very Day Year
Box 68760 e death certificate b the attending physi ed for use as the bu	Physician/Medical	past 12 months?  1 Yes 2 No 9 Unkn	own 9 Unknown	of death	r (Specify)				
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duires then signe	ted by					_	1 Yes		Probably 4 Unknown
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n of Vital Recting Physician: The After this certificate funeral director, page	B B	25. Was case referred to medical examiner?			26.Place of Death (0	Check only	1 ✓ Yes 2 one)	_No 1 <b>√</b>	Yes 2 No
of Vit	의	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient 28b. Time of Inju				sidence 6 🗸 Of	her: Scene
ion C tending eath. for: Aff	Certification:	1 Natural 5 Pendir 2 Accident Investi	g Jun 7, 2011	1809 hrs	1 ✓ Yes 2 I	leuk	ject shot s		
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hou hou		4 Homicide  29a. Certifier 1 Certifying Phy	sician: To the best of my know		d at the time, date and plac				, Randallstown, MD
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exam  29b. Signature and title of certifier	ner: On the basis of examinati and manner stated.	on and/or investigation	n, in my opinion, death occu	urred at the		d place, and due to 9d. Date signed (	
		Thead Vi	1 d 70.	λ	O.C.M.E.	ОСМЕ		iune 8, 2011	vonin, Day, Teal)
5	ŀ	30. Name and address of person w Theodore M. King, Jr., I			O W. Baltimore Stre	et Baltin	nore MD 3	1223	
Sta	_		32 Registrar's Sig		o VV. Daillinore Stre	ei, Daiiin	note, MD 2	1223	
Registi	ar	JUN I U 2	UTT Burn	B. Back					

DHMH 17 Rev 1/2001 OCME 2006

To the Hospital or Atteoding Physiciao: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attending about manifolds. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Zita Ita

Certification:

Medical

State Registrar 29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy findings available prior to completion of cause of death?  1 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical 26.Place of Death (Check or	nly one)
examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing	Home 5 Residence 6 ✔ Other: Scene
27. Manner of Death  1 Natural  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No  1 Yes 2 No	ed Describe how injury occurred Subject ingested methadone, alcohol, pregabalin and duloxetine
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2	Ref. Location (Street and Number or Rural Route Number, City or Town, State) 1745 Inverness Ave.
29a. Certifier ( Check only one)  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Year

29d. Date signed (Month, Day, Year)

June 3, 2011

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6ay DAVID LUTHER MILLER, JR. JUNE. 2011 09:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE BALTIMORE TIMONIUM 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth JULY 25, Year 953 Hours 1 X M 2 - F 57 217-62-5661 MD **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD HARFORD **JOPPA** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2403 BLUEFIELD CIRCLE 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 • No . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: WHITE 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 9:50 Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. SERVICE DISPATCHER B.G.E. Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DAVID LUTHER MILLER. SR. DORIS VOSS 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $643\ MILFORD\ CT\ ABINGDON,\ MD\ 21009$ PAMELA MILLER-EX WIFE permit. Page 1 and 2 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of W Burial 2 ☐ Cremation 3 ☐ Removal from State HIGHVIEW MEMORIAL 6/10/11 FALLSTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR Signatule of Funeral Service Licens 610 W. MACPHAIL RD BEL AIR, MD 21014 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ a LIVER CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery DAVID MILLER 3 Ctopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗆 No Yes 2 X No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) **HOSPICE** funeral 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🕱 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year, 201 of pe son who completed cause of death (Item 23a) (Type, Print) JACKIE JONES 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar			, , , , , , , , , , , , , , , , , , , ,	C	ertifica	te of	Dear	th		,	R	eg. No.	has V			
	sicia	ın/	1. Decedent's Nam	e (First, Midd	le,Last)	-		,					2	. Date of Dea Month	ith Day	Year		3. Time of Death	
edical Ex	ami	ner	Keith Allen Meekins											June 7, 2011			$\perp$	2128 hrs	_
												Location of	Death	4c. County of Death				ntv	
Fund	a rol		10433 Davis Avenue Woodstock Baltimore Count 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthg										-	_					
Direc			219-80-0631 1XM 2 F 52						Yrs.	Months Days Hours Min.						Foreign			
	any	- 1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City I										10d. Inside City Limits	s					
			MD Baltimore Woodstock									1 Yes 2 X No	0						
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he Ma	ified 2	Director	10433	Dozzia	A = = 0						211	163				USA	۸.		
with 1	or items 23a or 28a-f sho must be notified at once.		11. Marital Status	Davis		. Was Dece		U.S.			lent of His	panic Origii		cify Yes or No	)-	14. Race - A	meric	an Indian, Black,	_
death	r iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)									White, et	tc.						
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<b>0</b> 22,	1 1212 W. Old Liberty Rd., Winfield,											d,	MD 21784						
Physic			23a art I Enter the failule. List or	ne disease, or nly one cause	complication each I	ions that cau	used the dea	th. Do not	enter the	e mode	of dying,	such as car	rdiac or r	espiratory an	rest, sho	ock, or heart		Approximate Interval Between Onset and	
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<b>687</b> ertific	ding p		23b. Was decedent past 12 months	pregnant in tl s?	he I.	Live bir	th	2	Feta	al death	3 [	Ectopic	pregnand	у		Month	Da	ay Year	
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Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.		2												1Ye	s 2 🗸	No 3	Proba	ably 4 Unknown	
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ViSi or Att	in by	اقِ	2 Accident Investigation 2100 nrs 2100 nrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Conference of Town State)								nd Number o	r Rura	al Route Number, City	y					
Ours a	filled	Certification:	determined (Specify) Garage or Town, State)  10433 Davis Avenue, Woodstock, !									ck, M	ID						
) 24 h	within 24 nours after cean,  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Ea Ea	29a. Certifier (Check only one)	Certifying P	hysician:	To the best	of my knowl	edge, deat	h occurre	ed at the	e time, da	te and plac	e, and di	ue to the cau	se(s) an	d manner as	state	d.	
To Ta		Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.  29b Signature and title of certifier.											_					
		2	29b. Signature and title of certifier							29						(Month, Day, Year)			
			n									e 0, 2011	11						
15			30. Name and add	). Name and address of person who completed cause of death (Item 23a)  Ling Li, MD — Assistant Medical Examiner — 900 W. Baltimore Street, Baltimore, MD 21223															
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Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene

Tomas Mo-Choc 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 25, 2011 **Medical Examiner** 2147 hrs Tomas Mo-Choc 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 14142 Travilah Road Rockville Montgomery If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number un 6. Sex **Funeral** 7. Age (In yrs. last birthday) Foreign Director 1X M 2 F 27 Country) Guatemala Dec 29, 1983 Yrs Usual Residence of Decedent E I 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 Yes 2 No show Montgomery Rockville hours after death with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 14142 Travilah Road 20850 Guatemala Funeral 11. Marital Status -unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1XX Never Married 2 Married 2 X Nounk Yes Guatemalam White f Yes, Give Year or Dates: 3 Widowed 4 Divorced 1x Yes 2 No specify: Specify: unk hispanic ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed <del>un</del>k Pages I and 2 should be filed within 72 h ient of Health and Mental Hygiene ant: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Landscaping Laborer 6th unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk -unk-Be Federico Mo <u>Sebastiana Choc</u> ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vitim's Assistance of Montgomery 1County 20850
000 W: Dallings Street Rockville, Md. 2122 Bridgette McLean-case worker 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery other crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Minicipal Cemetery 8-2-11 Posa Del Santo, Guatemala Rinaldi Funeral Service 20910 5 21. Signature of Funcial Service Roma I 22. Name and Address of Facility Ph111p D. 21201 9241 Columbia Blvd.Silver 23a. Part I. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical 12-15,17-18.20a-c,22 per fh g916 6-27-11 vt attending physician or use as the burial -UNPENDED X AMENDED Box 68760, IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been uneral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' page ✔ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25 Was case referred to medical 26 Place of Death (Check only one) Division of Vital å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: May 25, 2011 1 Natural Subject assaulted 2130 hrs Director: 5 Pending 1 Yes 2 ✔ No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 14142 Travilah Road, Rockville, MD within 24 hours a To the Funeral I determined (Specify) A residence 4 V Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E May 26, 2011 Ch 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State egistrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend it em#20a-c.22perFH.G928 6/27/2012 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2011 OOPM ullivan /Medical 4c. County of Death 4a. Facility Name (If got institution, give street and number, 4b. City, Town, or Location of Death Examiner 1S 200mv If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign County) **Funeral** Year) Months Hours 1**∑**M 2□F Yrs. North Carolina Feb 4, 1947 578-64-0217 Director 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County unk 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylannet of Health and Mental Hyglene.
The state of Health and Mental Hyglene.
The state of the state of the than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner musts be notified at 1 ☐ Yes 2 XNo Martinsburg Funeral Director WV 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 25405 510 Butler Avenue USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Murphy Joseph Dorsey ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1951 Addison Road South District Hgts, MD 20747 19a. Informant's Name/Relationship (Type. Print) Dalecia Lyons/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place **Quantico National** 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of It Important: If Ite any Injury or ot 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Oremation 5 □Oremation 1 □ State Cemetery 06/28/11 Triangle, VA. 21. Signature of Funeral Service Licensee Ronald S. Wade Latney's Funeral Home 3831 Georgia Ave. NW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, April Shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): physician sthe burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes No 1□ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: ို 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Hagerstown MN Marsh Pike fol4 31. Date filed (Month, Day, Year State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	State o	f Marylar		artment of H		nd Me	ental Hyg	iene		00	
			State Registrar			tificate of D	Death		R	Reg. No. 20   84				
	Physicia	n/	Decedent's Name (First, Middle, Las	•						<ol><li>Date of Deatl Month</li></ol>	Day Year			
	Medic		Robert J.  4a. Facility Name (if not institution, give	nsey	# 01 T			June	7 2011   2:45 P M					
1	Examin	er	Renaisance Garden	,	nter	4b. City, Town, or Si 1 v.e	er Spr			4c. County of Death				
	Funeral				7. Age (In yrs. I		If Under 1 Year	If Under 24	4 Hrs.	8. Date of Birth				
	Director		330-10-3400	M 2 L F	90	Yrs.	Months Days	Hours	Min.	May 20,	1921	Country) New York		
Þ	how at	ř	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside	City Limits	
lanylaı	a-f s	Director	MD Montgomery Silver Spring										es 2 No	
the N	or 28 e not	Ωį	10e. Street and Number		10f, Zip Code	<del></del>		1	0g. Citizen of Wha	t Country?				
with	e filed within / 2 hours after death with the Maryland the Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	3128 Gracefield		209	904		United	States					
death											14. Race - American Indian, Black, White, etc.			
356 after	al", or Exami	d by	1 Never Married 2 Amarried 1 No									White		
hours	natura ical E	Completed	3 Wildowed 4 Divorced Year or Dates. W • W • II  15. Decedent's Education 16a. Decedent's Usual Occupation 16b K								16b. Kind of Busin	ess Industry		
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<b>2</b>	lygien her tl nt, the	Be C		Attorney	7			Contract Law						
and be file	ntal H ced of ced of	To B	17. Father's Name (First, Middle, Last)  James	0.	McK	Cinsey	]		's Name ( .ice	(First, Middle, M	laiden Surname) A	Anderson		
Maryland 21215-0036 2 should be filed within 72 hours after	and M is mar aumat		19a. Informant's Name/Relationship (T)			<del> </del>	ig Address (Street a			Davita Number				
32 Sh			Jean D. McKinsey				Gracefiel						0904	
ore,	of He fiterr rothe		20a. Method of Disposition	D 11		Place of Dispo	sition (Name of natory or other place		Da		20c. Location - Cit		-	
Page	ment tant: I		1 ☐ Burial 2XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				e Cremato		6/09	/2011	Be1tsv	ille, MD		
Baltimore, permit. Page 1 and	Department of Health Important: If item 27 any injury or other transmore.		21. Signature of Funeral Cervice Ligens		mo0382	177	Name and Addres app Funei	raffacility	d Cr	emation	Service	s 20910		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate											
Phy	ysician/	0 4	Immediate Cause (Final disease or condition resulting in death)  a. PNEUMONIA  Due to (or as a consequence of):  CHRONIC OBSTRUCTIVE PULMONARY DISEASE										Interval Between Onset and Death 2 MONTHS	
	Medical caminer												110	
	sician and burial-transit	er											RS	
, ed		Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury											
be executed		Еха	that initiated events c Due to (or as a consequence of):											
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. <b>6876</b> (certificate	ing ph as th	Med	IF FEMALE:											
X 6	ttendi or use	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy								23d. Date o Month	*		
. Box	/ the a	ysic	1   Yes 2   No								Wichtil	Total Day Teal		
cords, P.O. law requires that the	been signed by the attending I should be detached for use as	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing									ribute to the cause of death? 3 □ Probably 4 🙀 Unknown		
Uires	an sign uld be	ed k	DYSPHAGIA 1 - Yes 2 - No											
SO WE	as bee 2 sho	plet	CORONARY ARTERY DISEASE 24a. Was an autopsy 24b. V									re autopsy findings available or to completion of cause of		
Vital Records, sysician: The law requires	ate h	Completed	performed? de 1 □ Yes 2√√No 1 □										04455	
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Phys.	this cral dir	<u>۲</u>	1   Inpatient 2   ER/Outpatient 3   DOA   4XX Nursing Home 5   Residence 6									pecify)		
onibi	tth. : After : fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Mont	h, Day, Year)	injury	work'	? Yes 2 □ N	- 1	od. Describe nov	ibe how injury occurred			
DIVISION OF tal or Attending PI	er des ector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	28e. Place of Injury - At home, farm, street, factory, office					28f. Location (Street and Number or Rural Route Number,				
is D	within 24 hours after death.  To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 s													
Hosp		Medical	29a. Certifier (Check (											
To the	within To the compl	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)											
	, ,		Eleen aemme (OCRUP R158667 (6/7/2011											
11	bx,		30. Name and address of person who o				,				- 6 - 1 - 1			
			EILEEN GEMMELL C 31. Date filed (Month, Day, Year)				ELD RD.,	SILVER	SPR	RING, MI	20904			
	Stat Registra		IIIN 1 A 2014		egistrar's Signa	ture	4.1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month June MOSS Molly 2011 7:44 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Hebrew Home of Greater Washngton Rockville Montgomery 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Dec. 10 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Hours Year <sup>Country)</sup> Canada Director 383-01-1328 93 Dec. 1917 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD Montgomery Rockville 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Monument St. 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3XXWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Orechkin Golda Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Monument St., Rockville, MD Barbara M. Schaffer / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/12/2011 Birmingham, MICH. 4 ☐ Donation 5 ☐ Other (Specify) Clover Hill Mem. Park 22. Name and Address of Facility Rapp Funeral and Cremation Services 21. Signature of Fun tral service Licensee Gist 933 Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner SACRAL ULCER Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events nding physician and Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) page 2 should be detached signed by the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 After this certificate has 2 No 1 Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 808 w 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) MON ATELAM 6121 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8:09 PM Willis June 072011 James Malbaff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Westminster 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) **Funeral** Min. (Month, Day, Year) 01/25/1965 1 🛛 M 2 🗆 F Months Days Hours Country) Colorado Director 522-17-2456 46 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits 10b. County 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Prince William VA <u>Gainesville</u> 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20155 13241 Fieldstone Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. Specify: Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry ald be filed within ...
d Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 10 Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Malbaff James Η. Linda Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13241 Fieldstone Way, Gainesville, VA 20155 James H. Malbaff / Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 K Donation 5 ☐ Other (Specifi Anatomy Gifts Registry 06/09/2011 Hanover, Maryland 21. Signature of preral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death ENCEPHALLOPATH Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury g physician and is the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed PAILUBE 24b. Were autopsy findings available 24a Was an prior to completion of cause of death?

1 Yes 2 No performed' After this certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) INPASTENT Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 1 🗌 Yes 2 3 No မ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa re and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) S. Center Stwestminstor Md 21157 53 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** Mary E. Mielke 12:10 A.M 8 2011 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Health & Rehab Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 😿 F 243 26 6553 05/27/1924 N.C. 87 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Important: yor Items 23a or 28a-f show important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show important: If Item 27 is marked other than aging any injury or other traumatic event, the Medical Eventiner must be notified at once. 1 X Yes 2 □ No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4106 Grace Court U.S. 21225 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 □ No Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 7th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seth White Mattie Fischer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Catherine Smitley 3803 - 9th Street Baltimore, Maryland 21225 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 06/11/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur Funeral Service Licens Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician cerebrovalu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it an example of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) the ned 1 □Yes 2 □ No 9 Unknown 9 Unknown been signed by 1 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 MaNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 1 ☐ Yes 2 XNo al or Attending Physician: T s after death.
Il Director: After this certificat ed in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital the Funeral 29a. Certifier 1 stertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title e

30. Name and address of

rson who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $0^{\,\text{Day}}$ Physician/ JUNE 2011 4:20 P M STEPHEN JAY MOTTUS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 3502 SOUTHVALE ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Months Hours Min 0571671935 097-28-7310 76 Yrs NY Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a, State death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City. Town or Location Director 1 Tyes 2 X No MD BALTIMORE BALTIMORE 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 3502 SOUTHVALE ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Ayes 2 No Black. White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after of and Mental Hygiene. Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: WHITE Completed 3 X Widowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical soce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MONEY MANAGER FINANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARJORIE LIBERMAN ARTHUR MOTTUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 926 HILLSIDE AVENUE, EDGEWATER, MD KARIN MOTTUS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State BALTIMORE HEBREW CEM : 06/12/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. May 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death Immediate Cause (Final Kidney Pnysician/ disease or condition resulting in death) Medical Due to (or as a cons - uence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Une to for as a consequence on been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ympho cyti 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospita! Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Vatural 5 Pending injury Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Pcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29c, License number 29d. Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

samue

31. Date filed (Month, Day, Year)

Orleans

Balfimore MO

who completed cause of death (Item 23a) (Type, Print)

Pum

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Of Marylan		rtificate of D		F	Reg. No.				
	Physicia		1. Decedent's Name (First, Middle, Last)  Anna D. Niemeyer-Reite	r			2. Date of Deat June	th 8 <sup>Day</sup> 201	3. Time of Death			
	Medic Examin		4a. Facility Name (if not institution, give street and number)  1409 St. Francis Road	4b. City, Town, or l Bela			4c. County of Death Harford					
~ª.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month Day) NOV • 14	9. Birthplace (State or Foreign Country) PA				
36	aryland la-f show ified at	- H		City, Town or Lo Belai					10d. Inside City Lim 1 ☐ Yes 2 🔀			
	/ith the N 23a or 26 st be not	eral Dir	10e. Street and Number 1409 St. Francis Road		10f. Zip Code 21015			10g. Citizen of W USA	hat Country?			
	within 72 hours after death with the Maryland giene. then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	by F	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ★Widowed 4 □ Divorced  12. Was Decedent Ever in Uarmed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates.		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White			
Maryland 21215-0036	hin 72 hour ne. than "natur te Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give	edent's Usual Occupa kind of work done do DO NOT use retired) memaker	ition uring most of work	ing	16b. Kind of Bu				
nd 21	filed wit al Hygie d other event, th	Be B	12th  17. Father's Name (First, Middle, Last)			18. Mother's Nam		Maiden Surname, Nelso				
aryla	nd 2 should be lealth and Menl <b>m 27 is marke</b> her traumatic	욘	Augustus Verfaillie  19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ling Address (Street a	nd Number or Run	al Route Number	r, City or Town, Si	tate, Zip Code)			
as.			William Niemeyer /son  20a. Method of Disposition 20b	Place of Disp	49 Oak F		Date		e MD 21028  City or Town, State			
Baltimore,	Page 1 ment of tant: If it ury or o		1 ☐ Burial 2  Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bayvier Bayvier	w Cremat				imore MD			
Balt	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Sign, fure of Euneral Service Licensee	CI.	Connell	y Funer	al Hom	e of E	Balto. MD ssex 21221			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	nysician <i>i</i> Medical Examiner		disease or condition resulting in death)  a. Due to (or as a conse	equence of):	tu com	un.						
		iner	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying									
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or linjury	Due to (or as a consequence of):								
094	physicia the bur	edical	d									
Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant at 1 □ Live Birth 2 □ Femant at time 9 □ Unknown	Fetal death 3	Cother (specify)	ру 			te of delivery onth Day Year			
s, P.O.	uires that the des	d by Ph	Part II. Other significant conditions contributing to death but not	resulting in the	e underlying cause gi	ven in Part I.		tobacco use cont Yes 2  No	ribute to the cause of death			
Division of Vital Records,	The law require cate has been sid page 2 should b	Completed by						ppsy ormed?	Were autopsy findings availa prior to completion of cause death? 1 ☐ Yes 2 ☐ No			
ital	sician: The certificate rector, pag	To Be C	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:  1  Inpatient 2	□ EB/Output	Oth	er:		idence 6 Oth	er (Specify) Assite			
ν of V	ling Phys T. After this funeral di	ate: To	27. Manner of Death 28a. Date of injury (Month, Day, Year	28b. Time	of 28c. Injur worl	y at		how injury occurr				
)ivision	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Spe				28f. Location ( City or To	(Street and Numb wn, State)	er or Rural Route Number,			
_	Hospita 24 hours Funeral eted fille	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my kr only one) 3 Certifying Nurse Practioner: To the best of examiner:	ation and/or inv	actigation in my anini	on death occurred	at the time, date	and place, and de	IC to the cadacta and manner			
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	, my memory	29c. Licens			29d. Date signe	ed (Month, Day, Year)			
	6		30. Name and address of person who completed cause of death (	(Item 23a) (Type	e, Print)	16629		TUNE	', Lelj			
	N		31. Date filed (Month, Day, Year)  32. Registrar's S	w. mo	esha, l							
7	St	ate	31. Date filed (Month, Day, Year)	racro								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🦳 For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 9, 9:45 AM 2011 Physician/ Ostergaard Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Pikesville 10 Hiddenwood Ct. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year) Feb 28, 1932 Days 1 M 2 □ F Months Pennsylvania 79 Director 208-24-6558 Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a. State ms 23a or 28a-f sho must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2-No Baltimore Pikesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 21208 10 Hiddenwood Ct. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Examiner Armed Forces or Yes 2 No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: White 3 Divorced If Yes, Give Year or Dates. "natural", permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sessing Haus & Elementary/Seconday (0-12) College (1-4 or 5+) Ostergaard Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blume Knudson Elizabeth Christian Ostergaard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 Hiddenwood Ct. Pikesville, MD 21208 Gail Ostergaard /Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 11 Beltsville, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M01442 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF OROPHAMINX ANCEN Physician/ disease or condition Grantes Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by NUTRITLEN 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes (Anglanson's Disable 24a. Was an autopsy
performed?
Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 - Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ٥ MA

871

State Registrar 6569 N. Charles St. Baltimore, MD 21204

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month POPE 01: 20 A M RICHARD 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOWARD HOWARD COUNTY GENERA HOSATAL COLUMBIA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Hours Mar 14, Year) 930 1 ★ M 2 □ F 81 unk 579-42-3270 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 - Yes 2 1 No MD Howard Fulton 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12026 Scaggsville Road 20759 USA items unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married unk 2 No Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: and Mental Hygiene. white Specify: Completed 3 Widowed 4 Divorced THEFT 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 5755 Cedar Lane Columbia, MD Howard County General Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation & X Other (Specify) in state 21. Sign ture of Funeral Service State Addresoff Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between immediate Cause (Final Onset and Death Physician/ BLEED GASTROINTESTINAL 3 DAYS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant a been signed by the sahould be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Dav. Year) 050404 2011 JUN 04 PHYSICHN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ALKESH

DHMH 17 Rev 7/2009

LITTLE PATRIXENT

10632

Registrar's Signature

PATEL

D. 31. Date filed (Month, Day, Year) 井川

COLUMBIA

MD

21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death June 9, 201 1 5:10 A Physician/ Wilbur Dennis Peddicord Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice g. Birthplace (State or Foreign 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1914 Ohio Days June 10 297-05-8534 96 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c, City, Town or Location Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State Director 1 🗆 Yes 2 🔀 No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21014 1415 St. Francis Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Specify: White 5:10 a.m. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Medic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora May Goldsmith မ William Walter Peddicord 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1415 St. Francis Road, Bel Air, Maryland 21014 19a. Informant's Name/Relationship (Type, Print) Erma Z. Peddicord / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp | 6-11-2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or compli-shock, or heart failure. List only of Immediate Cause (Final Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) -transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 WILBUR PEDDICORD IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) led by the a Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 2 XNo 1  $\square$  Yes certificate has been si rector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be director examiner? 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 2 **X** No 1 Yes 2 within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury work?
1 Yes 2 No 5 Pending 1 X Natural Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check X 29b. Signature and tit

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30. Name and a

31. Date filed (Month, Day, Year)

JONES.

CRNP

DHMH 17 Rev 7/2009

State Registrar 2300 DULANEY VALLEY RD

on who completed cause of death (Item 23a) (Type, Print)

2011

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 20:04 Month Physician/ 2011 Medical n, give street and 4c. County of Death 4a. Facility Name (if not institution 4b. City, Town, or Location of Death Examiner Yospital Baltimore Maryland General If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year Country) 1 □ M 2 🗸 F Director 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No M 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ö Funeral items 23a 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Marital Status Armed Forces?

1 ☐ Yes 2 ☐ No Black White, etc. 1 Never Married 2 Married "natural", or ò Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam ည Koss injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) (SISTEX) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) s of Facility Funeral Service Licensee Name and Addr Fu Home, P. A. 21. Signature 23a. Part of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner museardial Infarction elevation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) Pregnant at time of death Unknown signed by the Ilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy n 24 hours after death. • Funeral Director: After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be 2 1 No Inpatient 2 □ ၉ 1 Tes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 89626 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m.D.40

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Medical Examiner 4a. Facility Name (if not institution, give street and number) or Location of Death 4c. County of Death altimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth

June 2, 1933 **Funeral** 9. Birthplace (State or Foreign 1 XM 2 □ F Days Min. 215-30-9437 Director Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director tx☐ Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 2500 W. Patapsco Avenue 21230 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 5 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft.
Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural",
any injury or other traumatic event, the Medical Exan Specify: white 1 ☐ Yes 2 X No Specify: 52-56 Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ education 12 teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Evdorg Franklin Wilbert Eugene Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Windy Meadow Court Randallstown, MD 2113 3 Vickie Reed/cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 X Donation 5 Qther (Specify) Signature reuneral Service Licenses, Nirector State and Address of Facility and 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Known Medical xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Live Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate 2 No nours after death.

neral Director: After this certificat
d filled in by the funeral director, p. 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manuer of Death Time of 28c. Injury at work? 28d. Describe how injury occurred 1 V Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 900 L OCH

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1:38 RM Month 2011 June 8, Richardson Linda Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 1003 Biltmore Ave. Anne Arundel West River 8. Date of Birth (Month, Day, Year) May 22, 1950 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** Min. Days 1 M 2 KF Months Hours  $\stackrel{Country)}{\mathsf{Ohio}}$ 61 Director 287-48-7299 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 1 Yes 2 No 28a-f MD Anne Arundel West River 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? ò Funeral 23a 20778 United States 1003 Biltmore Ave. items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Literary Writer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Department of Health and Ment. Important: If item 27 is marked any injury or other. Victor Hugo Lyons Eunice Annette Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Richardson / Husband 1003 Biltmore Ave. West River, MD 20778 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date
Jun 10 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f Yes 2 No g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Records, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 2011 Bonnie Dee Ann Robinson 7:42 ДМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Hospice House Talbot Easton Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min 1 M 2 X F (Month, Day, 09/22) Director 212-42-0953 67 1943 Pennsylvania Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 X Yes 2 No MD Talbot Newcomb 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7306 Woodside Road 21653 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Beautician Beauty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, uld be file | Mental F and Mental Department of Health and Ments Important: If item 27 is marked any injury or care. မ Paul Joseph Smith Amanda Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7306 Woodside Road, Newcomb, MD 21653 Leonard Robinson / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 106/09/2011 Hanover, Maryland 21. Signature of Aneral Service Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Immediate Cause (Final Onset and Death Physician disease or condition Hencetorena Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Examir Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ō Month Day Year Pregnant at time of death signed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed insulin regulary been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law has page 2 autopsy performed Yes 2 After this certificate 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to edical director, Be 26. Place of Death (Check only one) examiner? Other: ပ 1 🗌 Yes 2 M No 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year) work 1 Yes 2 No death. M after death □ Accident Investigation the. 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ap 29c. License number 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 555 Cynwood Drive, Easton, MD 21601 JUN 10 2011 32. Regi State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month achor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2023 E. 31th ST. N/A BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Days Min. Hours Director SOUTH CAROLINA 247-37-5093 6-20-1977 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MDN/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2023 E. 31th ST 21218 USA within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. ģ Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. BLACK "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -0-CLERK RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e BOYD MOODY GWENDOLYN REAVES injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GWENDOLYN JEFFERSON-HUEY (MOTHER) 2023 E. 31th ST. BALTIMORE, MARYLAND 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Buria 2 Cremation 3 Removal from State METRO CREMATORY 6-11-2011 BALTIMORE, MARYLAND 4 ☐ Doylation 5 ☐ Other (Specify) 21. Signature of Functal Service Licensee JONATHAN HIBNHR2. Name and Address of Facility PHILLIPS FUNERAL HOME, .P.A. D. tur 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or se a consecuence of) Examir resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ law requires that the death in the past 12 months? Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autons page To the Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other 1 Tes မြ 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending iniury work?
1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Britt Junis - Brace 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

MARIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 4:20 AM Month we ROTHSCHILD Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE KESWICK MULTI-CARE CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □XF 03/15/1943 Country) **Director** 68 LA 456-68-0511 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Maryland. 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5809 CLEARSPRING ROAD USA 21212 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify Completed 3 Widowed 4 X Divorced WHITE 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HOSPITAL ADMINISTRATOR MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ ROTHSCHILD MIRIAM ZESMER JOSEPH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1803 W. ROGERS AVENUE, BALTIMORE, MD 21209 JENNIE ROTHSCHILD/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHEARITH ISRAEL CEM 106/12/2011 DALLAS, TX 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., Mast Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Interstitual ling disease, hyperia, Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). signed by the attending physician and the detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy

| Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at time of death | Second at ti IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 □ Probably 4 □ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be lirector, page 2 s performe 1 Yes 2 No To the Funeral Director: After this certification of the Funeral Director: After this certification of the Funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) grego MD No Porhelle D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NEASELIE MEGREOR, 740 W. 40 Th

DHMH 17 Rev 7/2009

State Registrar

700 W. 40th STREET, BALTIMORE, MO 21211

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 2011 8:42 PM Marie Slais Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1007 Cliftonbrook Lane Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) ar 4, 1917 1 □ M 2 🛣 F Days Hours Director Czech Republic 216-68-2339 94 Mar Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1007 Cliftonbrook Lane 20905 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Completed Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever ည Voitech Kubs Anna Kubs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hana Svejda/daughter Department of Health Important: If item 27 any injury or other to once. 1007 Cliftonbrook Lane Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 6/4/2011 Woodbine, Maryland 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Sick Sinus Syndrome disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Year Pregnant at time of death Unknown 5 Other (specify) been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2X No eral Director: After this certificate filled in by the funeral director, pag 2 **X** No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Kesidence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number D35965 June 3, 2011

State Registrar David B.

31. Date filed (Month, Day, Year)

JUN 1 0 2011

Ste. 300 Olney, MD 20832

30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)

Harding 18111 Prince Philip Dr.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Stinnett Month Ivoria 8:40A M 2011 June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6850 Parsons Avenue Gwynn Oak Baltimore Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1 M 2 X F Director 215-14-0217 89 3/16/1922 or 28a-f show 10a. State items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 🔀 No MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6850 Parsons Avenue 21207 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or ite Black, White, etc. 2 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 😧 No 1 ☐ Yes 2 ¥ No Specify: Completed 3 Widowed 4 Divorced black Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Bell Atlantic 10th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold C. Mason, Sr. Bessie Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O'neal Stinnett/son 6850 Parsons Avenue Gwynn Oak, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park 6/10/11 Arbutus, MD 21. Signature of Fineral Service License 22. Name and Address of Facility 4300 Wabash Avenue March Funeral Home West Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atheroscherotic Eardiorascular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Disk to (unas a nonsequence dry Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 phy: anding pure IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 9 Unknown q | Linknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital Other: 1 ☐ Yes 2 ☑ No 은 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSKajapand M.D 00057465 6/3/11 Baltimore MO 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-203 N.S. Rajapakte M.D 2835 Jmith MV 31. Date filed (Month, Day, Year, State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and Important: If item 27 is no injury or other traumatic.		1 Burial 2 Cremation 3 4 Donation 5 Other Specify	<u> </u>	cre Che	matory or ot esapea	<sup>her place)</sup> ke Crer	n	June 7,	Be	eltsvil	le,	MD	
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Page 188	Examiner	Course Friter Underlying Cause (Disease or injury that initiated events resulting in death) Last									-		
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Division of Vital Records, P.O. Box 68760 To the Hospital or Atteodiog Physiciae: The law requires that the death certificate b within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at ti  9 Unknown		2 Fe	etal death ther <i>(Specify)</i>	3 Ectopic p	pregnancy	-	23d. Date of de Month	livery Day	Year	
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Vital hysiciae this cert	m	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatien	t 2 E	R/Outpatient		Other	Nursing Home	5 Res	idence 6	Other: S	rene	
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29b. Signature end title of certifier										d. Date signed une 7, 2011		, Day, Year)	
6		30. Name and address of person who Zabiullah Ali, M.D. Assi	completed cause of des stant Medical Exa		70.0	Baltimore S	treet, Baltim	nore, MD 212	223				
St Regist	9.50	31. Date filed (Month 14), Yar 2	32. Segistrar's	Signature	ba	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2011 Larry Godfrey Stancill 5. 3:13 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1209 Whitaker Mill Road Harford Joppa 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) NOV • 25, 1934 g. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days 219-28-0518 Director 76 Usual Residence of Decedent permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy rijury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland Harford Joppa 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1209 Whitaker Mill Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Mineral Elementary/Seconday (0-12) College (1-4 or 5+) / Operator Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Godfrey Lama Stancill Hazel Matie Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dobson L. Stancill / Son 10374 Georgia Circle, Morrison, CO 80465 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Tormation 3 Removal from State cemetery, crematory or other place 6-10-11 4 Donation 5 Other (Specify) Hilltop Service Corp Towson, Maryland Signatur Funer Service License McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Multiple Mus years disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Pregnant at time of death Day 1 Yes 2 g Unknown 2 No been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation To the Funeral irector: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral Medical 29a. Cert ier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Che Certifying Nurse Pranticeer To the best of my knowledge, death senimed at the time, data and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. D45390 \*18m completed cause of death (Item 23a) (Type, Print) 2.) 9114 Philadey Shia Road # 208, Bailtimore, MD 21237

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCI SCALES 10:00A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SECOURS HOS PITAL NIA BALTIMME, MU If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F 8-17-1922 Director NORTH CAROLINA 241-28-3299 88 Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 ¥ Yes 2 □ No N/A MD. BALTIMORE ŏ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 1702 N. ELLAMONT ST. 21216 USA items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 

↑ Yes 2 

No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: **BLACK** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic access. Elementary/Seconday (0-12) College (1-4 or 5+) -12-LABORER BETHLEHEM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ EUGENE H. SCALES GARDAH THORNTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOLORES SCALES (DAUGHTER) 1702 N. ELLAMONT ST. BALTIMORE, MARYLAND 21216 20a. Method of Disposition
1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6-15at2011 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS DWINGS MILLS, MARYLAND 21. Sign tun of Euroral Servic Licensee JONATHAN HIBNER2. Name and Address of FacilityPHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition RENAL END Physician/ STAGE DISENSE Medical resulting in death) Due to (or as a consequence of) **Examiner** MARETES Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events tran Due to (or as a consequence of): resulting in death) Last burial Physician/Medical certificate be P.O. Box 68760 phys iding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION; CARDIOMGO BATITY Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE LUND DISERSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HYPHOTHY ROID: C. DIFICILE COLITI 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 🛣 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1, Natural 5 Pending iniury within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier U- mogniteling 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

JUN 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Month SieHel : 45 A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **BALTIMORE** SEASONS HOSPICE @NORTHWEST HOSPITAL RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 🗆 F 0672071917 **Director** 212-12-5939 93 Usual Residence of Decedent artment of Health and Mental Hyglene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE **BALT IMORE** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 POMONA SOUTH, UNIT 1 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 
☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTANT ACCOUNTING 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLARENCE SAETTEL ANNA FEINBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETE SAETTEL/WIFE 10 POMONA SOUTH, UNIT 1 BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM 06/10/2011 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Matt Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Ph\_sician/ End Stage Cardionyopathy Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Linknown 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other Specify မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes s after death. 2 🗌 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ns Rajapamem.D 00057465 6/3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-703 Baltimore MD ZIZO9. N-S. RajapaKIC, M.D 2835 Smith Menue, 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ STEVEN DOUGLAS TILLMAN Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death . Sex 1XXXM 2 □ F If Under 8. Date of Birth (Month, Day, DEC. 31 Funeral 9. Birthplace (State or Foreign Months Min. Hours Director 59 214-62-2047 1952 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XXNo **BALTIMORE** MARYLAND ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HAMILTOWNE CR 21237 U.S.A. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH. GRADE MILITARY US GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KENNETH TILLMAN MARY LOUISE BUTSCHKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, DEBORAH TILLMAN/WIFE 2341 HAMILTOWNE CR. BALTIMORE MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) GARRISON FOREST VA CEM. 06/14/2011 OWINGS MILLS Signature of Juneral Service License MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR ROAD BALTIMORE 21206 23a. Part 1. Enter the dispase, shock, or heart failure. Lie Immediate Cause (Final ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Landen Due to (or as a consequence of) an ox Medical Examiner 010X1 Q Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury EXACE Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24 hours after death.
2 Funeral Director. After this certificate has I autopsy 1 ☐ Yes 2 ☐ No 2 1 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) 2 Yes 2 🗌 No Other: 1 🗌 Inpatient 2 🖫 ER/Outpatient 3 🗌 DOA 4 \Bullet Nursing Home 5 \Bullet Residence 6 \Bullet Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 2 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one \_ Cer ifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) D54725 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State 10 Registrar

			Please	State of Marylan	nd / Department of I	Health and Mo		_	10100	
			Registrar  1. Decedent's Name (First, Middle, La	et)	Certificate of	Death	Reg. I	NG U	18490	
	Physi Me	cian/ dical	Bernard J.	Tillman			2. Date of Death  Month  June	Day Year 2011	3. Time of Death 4: 47P <sub>M</sub>	
md	Exan		4a. Facility Name (if not institution, give 3602 Yennar	estreet and number) Lane		Timore		4c. County of Death	nore	
147	Funer Direct	_	5. Social Security Number 6. S	ex 7. Age (In yrs. It	ast birthday)  Yrs.  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year 0215	g, Birth	place (State or Foreign	
4	Maryland 28a-f show otified at	rector		more 10c. Cit	y, Town or Location Baltimore				10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
"	10c. City, Town or Location  Battimore  10c. City, Town or Location  10c. Cit								ntry?	
-7-	1 Never Married 2 Married 1 Yes 2 No							Black, White,	14. Race - American Indian, Black, White, etc.  Specify: Clack	
Ġ	1215-0036 hin 72 hours after ne. than "natural", o	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	life. DO NOT use retired)	of work done during most of working  Of use retired)			o. Kind of Business Industry  JOYHYOP GVUNNMAN		
		To Be C	12th grade  17. Father's Name (First, Middle, Last)  Benjamin J.	<u>2years</u> Tillman	Quality -	18. Mother's Name (		aiden Surname)		
an	altimore, Maryland mit. Page 1 and 2 should be filed partment of Health and Mental Hyporant; If item 27 is marked out y injury or other traumatic eventy		19a. Inform t's Name/Relationship (7		19b. Mailing Address (Street 2346 E. Fa	and Number or Rural F	Route Number, City	or Town, State, Zip	Code) MD 21239	
= 3	imore, M Page 1 and 2 s ment of Health lant; if item 27 ury or other tr		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	place of Disposition (Name of emetery, crematory or other place with the dispersion of the place	ce) Da	te 20c.	Location - City or T	own, State	
F	Baltimo	once.	21. Signature of Funeral Service Licens	see S	22. Name and Addre	ess Pacility Vau	ghn C. Gr.	seens Fur	roral Services	
Bernard	Sate be executed the bull of the burial-transit the burial transit the	cal Examiner	23a. Part 1. Enfer the disease, or com shock, or heart failure. List only of Immediate Cause (Erhal disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence)   ence of:	ig, such as cardiac or i	respiratory arrest,		Approximate Interval Between Onset and Death		
	'ital Records, P.O. Box 6876C sician: The law requires that the death certificate I certificate has been signed by the attending phys rector, page 2 should be detached for use as the	Completed by Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of pregnar 1 □ Live Birth 2 □ Fetal 4 □ Pregnant at time of d g □ Unknown	I death 3   Ectopic pregnand	су		23d. Date of deliv Month	ery Day Year	
	Records, P.O. The law requires that the ate has been signed by tage 2 should be detach	od by Phy	Part II. Other significant conditions of		- , , , ,		23e. Did tobacco	use contribute to t	he cause of death?	
h Mg	Record The law rectate has been	Complet	alcohol abu	min, recurr se, history	of prostate o	cancer	24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings available impletion of cause of	
No.	<b>fital</b> sician: certific irector,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Oth	ace of Death (Check or	nly one)			
-	of V ig Phys ter this heral di	te: 70	27. Manner of Death		28b. Time of 28c. Injury	4 □ Nursing Home	e 5 Residence d. Describe how inju	6 Other (Specify occurred	<u>/</u>	
	Division tal or Attendir s after death. al Director: Afted in by the ful	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		M 1 🗆	Yes 2 No	f. Location (Street a City or Town, Star	and Number or Rura te)	Route Number,	
	Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical (	I Check 2 □ Medical Exami	ician: To the best of my knowle ner: On the basis of examination e Practioner: To the best of my	and/or investigation in my opinic	on death occurred at the	due to the cause(s)	and manner as state	uealc) and manner stated	
4	To th. Within To th		29b. Signature and title of certifier	2C Jayl	29c. License			Pate signed (Month,		
	3		Bernitu C-	ompleted cause of death (hem.	23a) (Type, Print) 700 Ge if	ne Road	Suite	200 Cati	nsville	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Pegistrer's Signatu	h hard			many	lund 2/133	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 21.0 Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1 2:37A<sub>M</sub> 2. Date of Death Physician/ M. Ferdinand Tunis, RSM <u>2</u>011 JUNE Medical 4a Facility Name (if not institution, give street and number)
ST JOSEPH MEDICAL CENTER tb. City. Town, or Location of Death TOWSON **Examiner** 4c. County of Death BALTIMORE Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months Min. 1 □ M 2 □**X** Hours 7-1-19999 Country) Director 220-54-8861 Yrs MD Usual Residence of Decedent show 10a. State 10b. County 3 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f st notified MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number r items 23a or iner must be n ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral 6806 Bellona Avenue 21212 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: "natural" Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education be filed \ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Howard Hansel Tunis Fayetta Helena Willson 19a. Informant's Name/Relationship (Type, Print) Religious 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sisters of Mercy Order Belmont Baltimore, Mercy Drive. NC 28012 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 6-10-11 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati uneral Service Lice 22. Name and Address of Facility Bradley-Ashton Funeral Home, 2134 Willow Spring ROad, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause Filtre Indexlying Due to (or as a consequence of): Examir Cause (Disease or linjury sician and burial-tran Due to (or as a consequence of): resulting in death) Last anding physician use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown P.O. Hospital or Attending Physician: The law requires that the ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. THROMBOCYTOPENIA signed I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 🔀 No Other: မ 1 Propatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 🔲 Yes 24 hours after death. Funeral Director: A 2 🗌 No ☐ Accident the 1 Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number D 3 7 2 5 4 29d. Date signed (Month, Day, Year) 7 6 11 30. Name and address of person who completed cause of death (tem 23a) Type Print DRIVE TOWSON, MD BOON POH LIM, M.D. 7601 OSLER DRIVE TOWSON, MD

State

Registrar

31. Date filed (Month, Day, Year,

1 0 2011

32. Registrar's Signature

parke

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Norman Leland Ulsaker 2011 10:11 Ам June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Forest Hill Harford Hart Heritage Assisted Living Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 501-26-0948 80 Days Min Yer 931 March 25, Director Minnesota Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Maryland Harford 1 Yes 2 No Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1915 Rock Spiring Road 21050 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?. 1 X Yes 2 → No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 □ Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Agricultural Economist Government - USAID 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Ulsaker Mabel Helling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Beth Walker (Daughter) 325 Roundhouse Dr. Perryville, Maryland 21903 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 10, 2011 Evans Filhera logger other place) Bel Air Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Fygeral Service Licensee Jeffrey R. Testermen 22. Name and Address of Eacility Evans Funeral Chapel & Cremetion Services — ] 3 Newport Drive, Forest Hill, Maryland 21050 (M01543) Part 1. If the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician are as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2-1 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🔊 No 1 Yes 2 No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work? 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of g 29c. License number 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

1081

P.O. Box 68760

Division of Vital Records,

Macphail

615

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wem

31. Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Baltimore Johnnycake County  ${ t Baltimore}$ Social Security Number 219 80 9131 7. Age (In yrs. last birthday) **Funeral** Date of Birth 1 M 2 (Month, Day, Year) Director Usual Residence of Decedent 28a-f shov 10a. State 10h. County 10c. City, Town or Location the Medical Examiner must be notified at Director Baltimore County MD Baltimore Donathy Hopkins Winder 10f. Zip Code 21207 10e. Street and Number 10g. Citizen of What Country? 5610 Johnnycake Road "natural", or items 23a USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Completed 3 Widowed 4 X Divorced Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) B.S. Degree School Teacher Baltimore City other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William Hopkins Jr. Katherine Mae Veney permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4832\ Bowland\ Ave.\ Baltimore,\ MD\ 21206$ Janet Hopkins Hall-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State King Memorial Pk 6/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, MD 21. Signature of Funeral Service Licenses F/H 1101 E. 21202 22. Name and Address of Facility March MD Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes No
9 Unknown Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Month signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28c. Injury at work? Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) DO04393

3. Time of Death

9. Birthplace (State or Foreign

MD

10d. Inside City Limits

Approximate Interval Between

Dav

Year

Onset and Death

1 Yes 2X No

Country)

940 AM

State Registrar

31. Date filed (Month, Day, Year,

12

DHMH 17 Rev 7/2009

63

32. Registrar's Signature

30. Name and address of person who completed cause of death (form 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Marie Madeline Webster Medical 01 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death County of Death mose 100 ge (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** If Under 24 Hrs. 8. Date of Birth 1 □ M 2 😿 F Months Hours Min. **Director** 22-9432 -31-1928 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Md. Balto. 1 Tes 2 X No Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3726 Proctor Lane 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 🛮 Widowed 4 🗆 Divorced Specify: White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Mental Hygiene. Seafood Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ George Bonhoff Christine Biltz 19a. Informant's Name/Relationship (Type, Print) Important: If Item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health DTR Victoria Hurdle 9308 Kilbride Court Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 6-11-2011 <u>Holy</u> Redeemer Balto. Md. . Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome C 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between t and Deat Immediate Cause (Final -₽hysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 12 Yes 2 1 No Be 26. Place of Death (Check only one) Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred ☐ Natural Accident 5 Pending culth Walker rellwhile welking 104/201 UNK 1 Yes 2 🗹 No after death Director: / Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number of City or Town, State) determined building, etc. (Specify) Home within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b, Signature and title of certifie 9198 JUNE,8,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KeHasat 9000 Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year **DEBORAH** KAY WRIGHT Medical TIINE 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jun 12, 9. Birthplace (State or Foreign Country) West Virginia **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 M 2 X 263-17-2011 **Director** 1954 56 Usual Residence of Decedent show 10a. State with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7199 Cimarron Court Unit C USA 21703 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Black. White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7; nent of Health and Mental Hygiene. ant: If item 27 is marked other than in the stan in Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare |Lab Assistant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Craiq Spiker Helen Josephine Fritts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 7199 Cimarron Ct. Unit C Frederick, MD 21703 William D. Wright/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Final Journey Crematory 06/09/11 Woodbine, MD 21. Signatur of Funeral Service Lice Going Homes Cremation Service P.O. Box 784 MO1251 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Probable Myocardial Infarction Medical Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). Cause (Disease or iinjury that initiated events and trar Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 phy: IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ō Day Year Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q Diabetes Mellitus type 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic Kidney Disease 24a. Was an has autopsy performed page 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be director 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No ျှ 1 Inpatient 2 KER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 1564 Opossumtown Pk

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

MD

Melissa Asuncion,

D59542

Frederick, Md

6/2/11

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CHARLES AUGUST WEINREICH, JR. Medical JUNE 2011 <u>11:0</u>0P™ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GENESIS MULTI~CARE ~TOWSON TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) May 30, 1928 **Funeral** 9. Birthplace (State or Foreign XX M 2 D F Months Days Hours Min. 83 Director 219-22-9633 Maryland Usual Residence of Decedent show 10a. State at 10b. County 10c. Citv. Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Baltimore 1 ☐ Yes 2XXNo Baltimore County 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6505 Langdale Rd. 21237 USA Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 N Yes 2 No
If Yes, Give Korean
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify. XX Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) l vrs N/A Automobile Mechanic Schaeffer & Strohminger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Weinreich Marie Bohlen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Weinreich (Daughter-in law) 1902 Forest Guard Court Jarrettsville, Md. 21084 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mountain Christian C.¦6-9-2011 Baltimore, Md. 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Lassann Funeral Home 7401 Belair Rd. Balt Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) Month Day Year signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No. Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 4 Unursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. hly one) Signature D0060560 JUNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILADELPHIA KHETERPOL # 208, BALTIMONE, MD PANKAT 9106,

Registrar

DHMH 17 Rev 7/2009

onth, Day,

Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JACQUELINE Н. WILLETT 2011 June 9:50 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5905 Kingsford Place Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days (Month, Day, Year) Dec. 4. 1924 Director 579-42-6932 86 Yrs Dec. Washington DC Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code must be 10g. Citizen of What Country? Funeral items 23a 5905 Kingsford Place 20817 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner þ 1 Never Married 2 Married Black, White, etc. 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Completed 3 Widowed 4 X Divorced uth and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banquet Banquet Manager Catering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Heine Henry Pauline Duehay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robin A. Willett / Daughter 21013 NE 44th St., Sammamish, WA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Rock Creek Cemetery 06/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Washington D.C. Signature of Funetal Septice Licensee MC6382 Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 YEARS Immediate Cause (Final Ph\_sici\_n METASTATIC TRANSITIONAL CELL CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, is adding to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Exami ending physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year signed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE Completed 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital nours after death.

neral Director: After this or
dilled in by the funeral dire 2 XNo Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours a Medical 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ang itle of certifier 29c, License number D32033 JUNE 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 PETER G, HAMM M.D 5530 WISCONSIN AVE., CHEVY CHASE, MD 20815 31. Date filed (Month State 10 Registrar

			Ple	ease Type or P							•				
		1 - State of Maryland / Department of Health and Mer Certificate of Death							ivientai ny	Reg. No	2011	18498			
	1. Decedent's Name (First, Middle, Last)  Physician/ Willie Scott Warrington, J								2. Date of De Month June	eath	, 20 <b>Ĭ</b> Ĩ	3. Time of Death 4:45 P. M			
-	Examir		4a. Facility Name (if not institut Edenwald			, or Location of Deat $\Gamma owson$	th	4c.	. County of Death Baltin						
I	Funeral Director		5. Social Security Number 217–03–7715	6. Sex 1 🕅 M 2 □ F				ar If Under 24 Hrs s Hours Min		1.5 <sup>ear)</sup> 1	9. Birth Cour	place (State or Foreign ntry) Maryland			
	and show	or	Usual Residence of Decedent  10a. State 10b. Cour	nty	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits			
	r 28a-f	Funeral Director	Maryland Bal	timore		Towso	n 10f. Zip Code			10g Cit	tizen of What Cou	1 🗆 Yes 2 💢 No			
	with th	eral	800 Southerl	v Court			101. ZIP COU	21286		Tug. Cil	U.S.A.	ntry:			
920	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fune				11. Marital Status  1 Never Married 2 Nover 1 Divorce 4 Divorce 4	12. Was Deceden Armed Forces 1 X Yes 2	3?	3. 13. Y	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (S ıban, Mexican, Puer No S <i>p</i> ec <i>ify:</i>	pecify Yes or No to Rican, etc.)		14. Race - Americ Black, White, Specify: Wh	
21215-0036	72 hour n "natui fedical		(Specify only hi	dent's Education ghest grade completed)		16a. Deced	lent's Usual Occ kind of work don O NOT use retire	e during most of wa	rking	16b. K	ind of Business In	dustry			
212	within rgiene. <b>er tha</b> l t, <b>the N</b>		Elementary/Seconday (0-12	college (1-4 o 2 years	or 5+)	Manufacturing Representative					Electronics				
pue	be filed ntal Hy ed oth	To Be	17. Father's Name (First, Middle Willie Scott		Sr			1	ame (First, Middle, Maiden Surname)						
Maryland	2 should be filed within 72 h and Mental Hygiene. 77 is marked other than "traumatic event, the Med	ľ	19a. Informant's Name/Relation		DI.	19b. Mailir	ng Address (Stre	Naomi et and Number or Ri		er, City or		code) 21204			
	and 2 st Health a tem 27 is		Joseph N. Kar	ey (atto		305 V	Vest Che	sapeake <i>I</i>	Avenue l	Balti	more, Ma	ryland			
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3 Removal from Sta	<sub>ite</sub> c	emetery, cren	sition (Name of natory or other p Lev Memor	ial Grdns.	Date 6-11-11		ocation - City or Tonium, M				
Balti			21. Signature of Funeral Service					ress of Facility -Wiedefel k Road I							
Associated in the second	Physician/ Medical Examiner	ı	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	or complications that cause of each I a.  Due to (or a b.	ine.	h. Do not ente	er the mode of o	ying, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between Onset and Death			
68760	uth certificate be uttending physici or use as the bu	Completed by Physician/Medical Examine				if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or a	as a consequ	uence of):	·ivm					
. Box 68						ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1	h 2 🗀 Feta t at time of d	aldeath 3 🛚	Ectopic pregna				23d. Date of delive Month
s, P.O.	requires that the des been signed by the s should be detached t			Part II. Other significant cond	itions contributing to death	but not res	ulting in the u	nderlying cause	given in Part I.			use contribute to t	the cause of death?		
of Vital Records,	The law requivate has been page 2 shoul									opsy forme <b>d</b> ?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of			
/ital	ıysician: The iis certificate director, pag	) Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐	Hospital:	-111 0 🗆	FD/O: 441		Place of Death (Che		:	0 Other (Specif				
	ng Pł fter th ineral	te: To	27. Manner of Death  1 Datural 5 Per	28a. Date of in	njury	28b. Time of injury	28c. In		28d. Describe			7)			
Division		Certificate:	2 Accident Inve 3 ☐ Suicide 6 ☐ Cou	stigation ild not be 28e. Place of I	njury - At ho etc. <i>(Specif</i> y	ome, farm, stre	M 1 eet, factory, offic	Yes 2 No		(Street and wn, State)	d Number or Rura )	d Route Number,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medica	ing Physician: To the best al Examiner: On the basis or ing Nurse Practioner: To the fier	f examination	n and/or invest	igation, in my op leath occurred at	inion, death occurred	at the time, date	and place he cause(s	e, and due to the ca	ause(s) and manner stated tated.			
	F ≥ F ŏ			My hi	Brica	in		a9 >	49	,6	18/11	/			
_	le		30. Name and address of person	on who completed delaye of	death (Item	23a) (Type, P	161	v. follo	ng Pa		In Kol	M4238			
	Sta Registra		31. Date filed (Month, Day, Year	32. Rajis	strar's in	6-3-3				- /	1 7				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 81,99 State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 5/20/2011 9:20 P Physician/ Gail Arlene Brown Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Worcester Berlin 5 Dove Lane 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9/14/1948 **Funeral** Days Hours Min 1 □ M 2 1 F 215-52-2411 62 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State death with the Maryland must be notified at Director 1 Yes 2 No Berlin or 28a-f MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA Funeral 21811 23a 5 Dove Lane ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other training or other training. Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔼 No þ 1 Never Married 2 X Married Yes Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Howard Co. Schools secretary 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Thelma Jeanette Zennell Albert William Styles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dove Lane Berlin, MD 21811 Dexter Brown, Jr. (husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State First State Crematory 5/26/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home Service Lice 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Year in the past 12 months?

1 Yes 2 No Month Day the 9 Unknow 23e. Did tobacco use contribute to the cause of death? been signed by nt oonditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform 2 🗌 No 1 Yes Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Certificate: To Be examiner? Other: 2 XNo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at hours after death. uneral Director; After work? 1 Yes 2 No 1 Natural 5 Pending M Investigation Accident the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide filled in by 4 Homicide determined To the Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотріете (Check Certifying hurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce geted cause of death (Item 23a) (Type, Print 30. Name and address State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 07:57A M Leonard E. Bonneau, May Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4104 Carozza Court Prince Temple Hills George's 6. Sex 1 ♣ M 2 ☐ F 9. Birthplace (State or Foreign Country) SC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday Funeral Days Hours 1 0 / 30 / 1939 71 **Director** 52 6341 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Prince George's MD Temple Hills 10e. Street and Number 10g. Citizen of What Country? Funeral 4104 Carozza Court 20748 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces'
1 X Yes 2 C Black, White, etc. þ 1 Never Married 2 Married Specify:Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Bonneau Alma Polite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s f Health item 27 Lisa Crawley/Daughter Jefferson St.NW Washington, DC 20011 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/27/2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between 23a. Pmt 1. Enter the discussion shock, or heart failure. List only one cause on each line. Onset and Death Lymphoughic Immediate Cause (Final Mronic Physician/ disease or condition resulting in death) month Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to in medicause. Enter Underlying Due to (or as a consequence of) Examin the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death be detached 1 ☐ Yes 2 L 9 ☐ Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **X** No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? injury 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in revenience death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

B3+1 State

Elizabeth K.Pf/affenroth,M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

address of person who co

cause of death (Item 23a) (Type, Print)

1221

29c. License number

D0068056

Mercantile Ln.Largo, MD 20774

29d. Date signed (Month, Day, Year,